SOCIAL AND ECONOMIC CONSEQUENCES OF FAMILY PLANNING USE IN SOUTHERN PHILIPPINES

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Family Health International
Women's Studies Project

RIMCU

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- Office of Population Studies, University of San Carlos
- Social Science Research Institute (SSRI) of Central Philippines University
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Magdalena C. Cabaraban, Ph.D.

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Executive Summary

For nearly five decades, family planning was made the cornerstone of the worldwide strategy to slow down population growth. Recent international meetings, notably the International Conference on Population and Development (ICPD) in Cairo and the Fourth World Conference on Women in Beijing, brought changes to population policies and strategies. Family planning as an approach to population growth reduction was modified and recasted in the reproductive health framework.

Early studies on family planning were centered on examining and predicting factors influencing the decision and practice of family planning use. Research questions revolved around determinants in the use or non-use of contraception. In recent years, however, the interest took a reversal. Family planning began to be viewed as a way of making changes in women lives, either directly or indirectly.

The need to investigate how family planning affects women's lives has led to the creation of a unit, the Women's Studies Project (WSP) under the Family Health International. WSP, to date, has several on-going studies about the multi-faceted effect of family planning use on women's lives in various parts of the world.

Three academic institutions, the Office of Population Studies (OPS) of the University of San Carlos in Cebu City, the Social Science Research Institute (SSRI) of Central Philippines University in Iloilo City and the Research Institute for Mindanao Culture (RIMCU) of Xavier University, Cagayan de Oro City in partnership with local NGOs undertook research studies under the guidance of Inter-Country Advisory Committee (IAC) and monitored by the Institute for Social Studies and Action (ISSA).

While the overall objective of inter-country research is the effect of family planning use on women's lives, this study focuses on four specific objectives, namely: to describe women's strategic and practical reproductive needs and how the use of a family planning method makes a difference in women's reproductive health; to determine how family planning use is associated with women's employment, household tasks and domestic work, family roles and interpersonal relations; to measure contraceptive failure and determine possible explanations; and to examine the prevalence of domestic violence and its socio-economic demographic correlates.

The study utilized both quantitative and qualitative research modes. The quantitative data was derived from longitudinal survey of 660 rural currently married women of ages 15 - 49 from Bukidnon province and a cross-sectional survey of 1,000 women of the same age range from urban communities in Cagayan de Oro City. The qualitative component of the study consisted of three pre-survey Focus Group Discussions (FGDs) and five post-survey FGDs.

The highlights of the findings are:

- There is a disadvantaged position of households in depressed and in cultural minority areas of Bukidnon in terms of income, material possession, and household amenities
- Gender-biased ownership and control of household resources exist.
- Reproductive needs of never users are greater than current users in terms of family planning and reproductive health knowledge, difficulty in conceiving (infertility), and in utilization of reproductive health services.
- In general, forty-six percent (46%) of women in the study experienced unwanted pregnancies that led to a stressful relation between husband and wife.
- Family planning services considered as most important are user-friendly staff, clean clinics, and accessibility of service points.
- Experience of physical abuse is reported by one in every four women; these abuses happened when the husband was drunk, and during quarrels or disagreements.
- Urban residence, husband performing household tasks, and wives making decisions on the manner of disciplining children are significant correlates of domestic violence.
- Women's hours in domestic work increase as the number of children increase. Having children under five years of age significantly reduces the number of hours that women spend in market work and the likelihood that women can work for pay.
- The Pill and the IUD are the most widely used contraceptive methods but the most effective are injectables and tubal ligation.
- Condom use and withdrawal methods are reported to be most ineffective.
- Contraceptive failure among users is caused mostly by improper use of methods rather than by method failure.
- Fertility is <u>not</u> a key factor in Filipino household power allocation. Users of family planning have more influence in fertility decision and that, which involves "what family planning method to use."
- Wife's income increases her influence in decisions involving purchase of expensive items, giving support and assistance to relatives, and whom to vote during elections.
- Women with more years of schooling have more influence in household decisions compared to women with fewer years of schooling.
- The qualitative results indicate that:

    - Muslim and Non-Muslim women viewed work, leisure, and rest in similar perspective;
    - Decision-making differs between Muslim and Non-Muslim households. Tradition, culture, and religion give little decision-making power to Muslim women;
    - Women's power to decide increases if they are economically independent;
    - Division of labor is strictly followed in Muslim households; and
    - Women indicate that religion and tradition are the major reasons why most do not use a family planning method.

The recommendations articulated under the different analyses can be categorized under the rubric of advocacy (for policy/legal changes as well as changes in people's behavior), upgrading and enhancing health services with special emphasis on reproductive health, and the integration of women's concern in the development process through consciousness-raising, education, and information dissemination.

Specific and "doable" suggestions were enunciated and directed in three levels: the individual, the family and other institutions, and the community. On the individual level, recommendations include consciousness-raising among men in sharing reproductive tasks especially nurturing activities and involvement of men in planning and managing family responsibilities. Women awareness and knowledge should be strengthened in terms of reproductive health and reproductive choices. The multiplier effect can be in the form of mothers educating their adolescent children.

On the family and the institutional level, suggestions include: urban-based women's group can reach out to rural women's group for assistance in the advocacy efforts; creation of a dedicated and committed core group of volunteer couples to provide information, counseling, education and training on reproductive health, gender and sexuality; the local health board should supervise and monitor budget allocation to health and women's activities; clusters of housewives can be created to work together according to principles of reciprocity and self-help, for example, alternately taking charge of children's day care within the neighborhood.

On the community level, there is a need for greater participation of women in local governance, networking of women's groups with a larger group, improvement of women's access to information and better quality of health services, integration of women's concern with religious tenets and activities, promotion of equality in the workplace and emphasis on equitable gender relations ins schools, and sustainability in local government units' concern to improve women's condition.

Chapter 1

Introduction

For nearly five decades, the concern on the galloping population growth and its interacting effects on human lives spurred global and concerted efforts to slow down the pace of population increases. Over this period, strategies were developed, discussed, and reviewed resulting to international forged agreements. Approaches to population reduction underwent refinement from the limited frame of family planning to expanded reproductive health, with emphasis on voluntary and quality choice of couples.

Family planning became the cornerstone of a worldwide strategy to slow down population growth. Massive funds were poured into family planning programs, especially in third world countries where population growth rates are so much higher compared to those of developed countries. In the 1950s and 1960s, a few donor countries notably the United States of America and Sweden, provided international population assistance. The success generated by such assistance propelled other industrialized countries to join in the provision of funds for population reduction.

The initiative of the donor countries paid off more than a hundred fold. Almost all developing countries instituted government-sponsored programs providing family planning services. The commitment on the amount of population assistance however dwindled after more than three decades of international cooperation (PAI, 1997). Nevertheless, developing countries have been able to mainstream family planning services into their health delivery programs.

The process of ensuring sustainability and integration of family planning services into the over-all health program has barriers to contend with. Criticisms arise from different sectors that family planning programs are instituted by governments mainly to support the goals of economic development and that these programs have failed to address the real concerns of women who are supposed to be the beneficiaries of family planning. Other criticisms also include the claim that family planning programs have had no real impact on population growth, and that the millions of dollars that had been poured into these programs had only been wasted. These critiques argue that the amount spent on family planning should have been used for other more worthwhile programs, such as delivery of critically needed social services that could do more good for the populace (Meier, 1989).

Notwithstanding detractors of family planning, the program is responsible for slowing down the growth of the population (PAI, 1997). Such recognition is widespread, albeit the other social strategies also contribute to decelerate growth of population, notably greater access to education for girls and better economic opportunities.

The slowing down of population growth resulted to documented multiplier effects on a country in particular and the world in general. Gross National Product (GNP) is said to grow fifty percent

(50%) faster than the average (Population Reports, 1994). The interlocking concern on environmental degradation and preservation of natural resources produced alarm to many people and the government; reactive and proactive responses were generated and translated into action plans.

Indeed, the delivery of family planning services is an essential element in population efforts especially in developing countries. However, the rationale for family planning (FP) programs should not focus largely in terms of macro-level phenomena with emphasis on economic and biological benefits said to flow from reduced rates of population growth. This was considered a shortsighted view, because the empirical relationships found at this level are often tenuous (Kelley, 1988) and it ignores the significant and beneficial effects which FP use may have upon individuals and households. Family planning is considered as a life saver for millions of women and children (POPLINE, 1997; Population Reports, 1994), world leaders and population experts concurred on the astonishing health care produced by the ripple effect of family planning on the lives of women and men.

Population Reports (1994) enumerated such advantages. Family planning protects women from unwanted pregnancies; an estimated 400 million unwanted births had been avoided since the 1960s. It also saves children's lives through longer birth interval. Husbands, because of smaller number of children, can provide a better life for their families. Couples can send their children to school and afford longer years of schooling.

The success in family planning affects many areas in women's lives. A report linking together data from 42 countries depicts conditions, patterns, and trends which bring closer the gap in women's aspirations and their reproductive experiences (The Alan Guttmacher Institute Report, 1995). Nonetheless, in spite of the rapid increase in the use of contraception, a very large proportion of women of reproductive age are in need of contraception, have limited contraceptive choices and limited access to family planning services.

Country-Based Justification of the Study

In consonance with worldwide interest on the reduction of population growth, studies and scientific investigations in the Philippines reflected the same concern. The foci of earlier demographic studies were on trends and patterns of population growth. It was only in the period of the fifties when fertility and family planning gained wider interest, coverage, and concentration (Concepcion, 1998).

As a movement, family planning came to be identified as a means of controlling rapid population growth. Of the three demographic factors, which explain why there is population growth or decline, fertility and fertility management became the centerfold on which policy and program formulation hinges upon.

During the early seventies, the Philippine Population Program focused on fertility reduction with family planning as its main approach (POPCOM, 1995). It was during this decade that the

Philippine government enunciated clearly its mandate and Republic Act 6365 made imperative a family planning program that respects the religious beliefs of individuals. Towards the end of the '70s and the early years of the '80s, the population program expanded its concern beyond fertility reduction to include family welfare. As a strategy, family planning is considered the core element of any socio-economic program. Moreover, Primary Health Care and Maternal and Child Health became a strategic thrust of family planning.

Further policy changes took place as international efforts focused on women's concerns and issues. The Women in Development (WID) framework crafted during the Nairobi Conference made inroads into the consciousness of health policy-makers. Thus the family planning thrust was recast in the WID mold.

Major international events during the last five years which include the International Conference on Population and Development (ICPD) in Cairo and the Fourth World Conference on Women in Beijing brought about more changes in population policy and, in turn, influenced the direction of family planning. The gender sensitive population policy framework leads to the recognition of men and women's practical and strategic gender needs as well as their reproductive rights.

Concomitant with policy changes were the changes in direction and concentration of research. Prior to the mid-fifties, research topics revolved around population growth. Interest in fertility studies started when the Philippine Statistical Survey of Households (PSSH) under the Bureau of Census and Statistics included data items for ever-married women in 1956. Consequently for the period of 20 years from 1968 until 1988, fertility and fertility management studies concentrated on the following determinants: nuptiality, contraception, and post-partum behavior.

An earlier study by the University of the Philippines Statistical Center and Population Institute unveiled widespread ignorance and confusion. Contraception was often mistaken as induced abortion.

Fleiger (1998) noted that the justifiable interest on fertility reduction in the span of three decades was accompanied by the unjustifiable neglect of the consequences of such reduction, particularly on the economic and social repercussions of population aging.

A considerable number of studies revolve around the association between fertility reduction and contraceptive use (Perez, 1997). Macro-level analyses relate the impact of marriage, post-partum infecundity and induced abortion (Bongaarts, 1984) to fertility decline. Casterline (1991) attributed the changes in contraceptive behavior as the dominant source of total fertility decline. A United Nations study of some 120 countries in 1994 affirmed the strong association between fertility and contraceptive use.

To date, in congruence with country population program thrusts and with encouragement from several funding agencies, research studies generally deal with the determinants of family planning. Few studies in the Philippines have attempted to deal with the effects of family planning on the various facets of women's lives. Scant attention has been given to the consequences of family planning use in the areas of personal autonomy and self-esteem, community participation, employment, leisure and rest, and family relationships.

Worldwide, early research interests were on examining and predicting the factors impinging on contraceptive use or non-use. One assumption is that contraceptive methods are designed for women's use and the traditional outlook that family planning is a woman's responsibility (< biblio >) reinforces this. Social, cultural, economic, demographic, and psychological factors were identified and studied as explanations to the likelihood and pattern of family planning use (Chung, et. al., 1972; Bulatao and Lee, 1983; Mason, 1984 as stated in Hardee, et. al., 1996;).

However, as early as the mid 70s, Dixon had already sown the research question on how family planning affect's women's lives. Although the idea did catch the attention of a few social scientists, it was the articulation and challenge posed by Hong and Seltzer (1994) that set family planning research towards a new direction. Prior investigations on women's status, gender relations, women's empowerment and quality of life provide indications that family planning indeed affects various domains of women's lives.

A conceptual framework, which depicts the path of relationship between use and non-use of family planning and domains of women's lives, was developed by the Women's Studies Project (WSP) of the Family Health International (FHI). The framework segregates several levels of factors where one could focus on how family planning showed impact or consequences on women's psychological and physical aspects of her life, of her household/family roles, and her societal and economic roles. Moreover, the woman's family planning experiences and domain of life are influenced by life cycle events, gender norms of the community/society as well as the social, political, and economic conditions which she encounters.

Objectives of the Study

The Women's Studies Project (WSP) conceptual framework (Figure 1) provides direction to the present study. The overall objective is to investigate the effects of family planning use on women's lives.

The specific objectives, however, cover a wider scope and include specific issues and concerns of women:

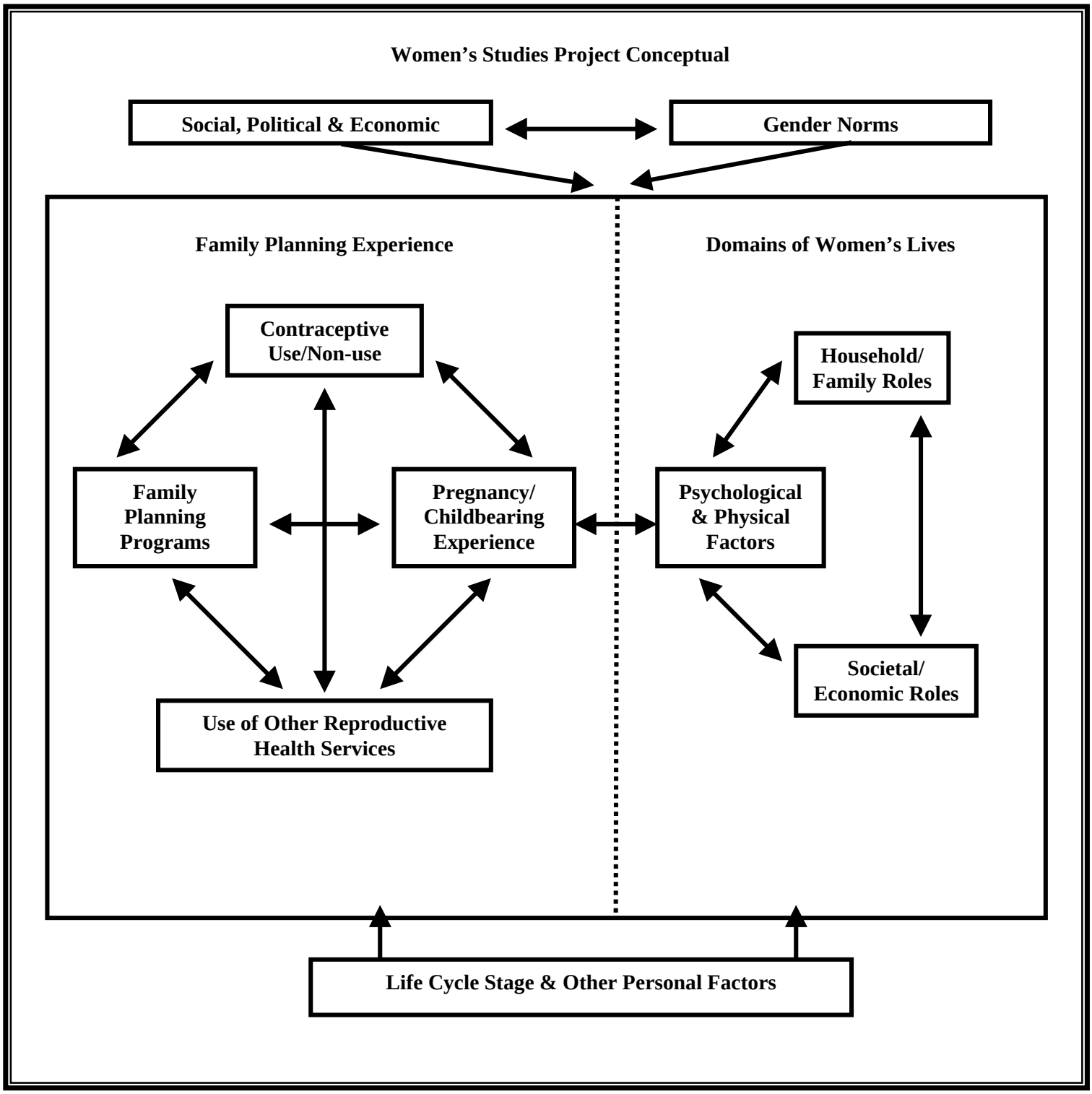
1) To decide women's strategic and practical reproductive needs and how use of a family planning method makes a difference in women's reproductive health,

2) To determine how family planning use is associated with changes in the following areas of women's lives:

- employment
- household task allocation and domestic work
- family roles and interpersonal relations

3) To measure contraceptive failure and determine possible explanations, and
4) To examine the prevalence of domestic violence and its socio-economic, demographic correlates.

Figure 1.


Women's Studies Project Conceptual
Social, Political & Economic
Gender Norms
Family Planning Experience
Domains of Women's Lives
Contraceptive Use/Non-use
Household/ Family Roles
Family Planning Programs
Pregnancy/ Childbearing Experience
Psychological & Physical Factors
Societal/ Economic Roles
Use of Other Reproductive Health Services
Life Cycle Stage & Other Personal Factors

Chapter 2

The Research Methodology

***Research Design and Method of Data Collection*.** Both qualitative and quantitative research modes were utilized in this study. Designed to complement each other, the qualitative component consisted of three pre-survey and five post-survey sessions of Focus Group Discussion (FGD).

The pre-survey FGDs were conducted to elicit ideas and insights primarily on the concepts of leisure/rest, decision-making, contraceptive use, and sexuality issues. Participants in these sessions were pre-selected Muslim, urban, and rural women. The results of the pre-survey FGDs were used in the design and formulation of questions in the survey instrument.

The post-survey FGDs were utilized as supplementary data to the survey findings, to enhance the quantitative results by providing more depth and sensitive insights to the realities uncovered. Five sessions of post-survey FGDs were conducted among pre-selected husbands and women in urban, rural and predominantly tribal areas. Topics tackled during these sessions include: unwanted pregnancy, task allocation, decision-making, domestic violence, and income.

For the quantitative component, a sample survey was conducted in purposively selected urban and rural sites. The sampling procedure in the selection of barangays (the smallest administrative/political unit of the country) is described in the succeeding section.

A survey instrument was given structure and flesh in a WSP-sponsored workshop purposely convened for the construction of the questionnaire. Together with other in-country research teams, the framework, format and data items were discussed, assessed, and critiqued. Each team was allowed flexibility regarding the formulation and preferred data items to be included in their survey instrument, albeit team members included core questions for comparability purposes.

The survey instrument underwent reviews from peers, consultants and the Ethics Review Board. The process yielded suggestions that fine-tuned the instrument. Moreover, investigators performed several “walk-through”, to check the logical flow of questions as well as clarity of the instrument. A flowchart was designed to clearly delineate who should answer which questions.

The survey schedule contained the following data blocks:

- Life Cycle Stage and Personal Data
- Household Attributes/Characteristics
- Contraceptive Use and Non-use
- Pregnancy History
- Experiences with FP Services
- Men and FP
- Decision-making and Communication
- Reproductive Health Concerns and Services
- Psychological and Physical Factors
- Domestic Violence
- Self-esteem Questions
- Household Tasks

The interview schedule was developed in English and later translated to the local dialect and pretested. The translated version was subject to re-translation to English to ensure that meaning and nuances of concepts were not lost or distorted. Respondents involved in the pretest were representatives of rural, tribal, and urban women.

Flaws and inadequacies uncovered during the pretest were corrected. Terms, phrases and sentences, which the respondents found difficult to understand, were either replaced, deleted, or modified. Illogical flow of skip instructions was corrected. Prior to the reproduction of the final instrument, investigators checked and counter-checked the placement and flow of questions.

***The Sample Selection*.** The sample sites were Bukidnon province, categorized in this study as a rural area, and Cagayan de Oro City, as an urban sample. For the latter, the sampling frame was a list of barangays classified as urban by the National Statistics Office in their 1990 Census. Those classified as rural were excluded from the frame. A two-stage selection process with probability proportional to the household size followed. Twenty barangays (Table 1) were chosen during the first stage; fifty households were drawn by systematic sampling from each of the selected barangays. Over all, 1,000 households were included in the study.

Table 1. List of Urban Barangays, Women's Studies Project. Cagayan de Oro City, 1996.

1. Balulang	11. Cugman
2. Barangay 16	12. Iponan
3. Barangay 29	13. Kauswagan
4. Bonbon	14. Lapasan
5. Bulua	15. Lapasan
6. Camaman-an	16. Macabalan
7. Camaman-an	17. Macasandig
8. Carmen	18. Patag
9. Carmen	19. Puerto
10. Consolacion	20. Puntod

Bukidnon sample areas were the same barangays covered in a 1994 UNICEF-funded study on Maternal and Child Health Care. The areas were selected by multi-stage cluster sampling. However, a prior stratification procedure was implemented. From the 441 barangays of 22 municipalities, three sampling frames were constructed: the first frame consisted of six municipalities with the tribal household population exceeding 15 percent of the total population

in 1990; the remaining 16 were stratified into depressed and non-depressed sampling frames. The stratification was made according to the following indicators: percent of households with piped water, percent of households with electricity, number of Barangay Health Stations, and number of health personnel.

Sample municipalities were drawn from each of the frames, the selection of which was by probability proportional to the size of households. The next stage was the selection of sample barangays; a total of 22 barangays were drawn for the sample. The list of these places is given in Table 2.

Three barangays were replaced as per advice by the local government units and the military. The replaced areas had serious peace and order problems, thus, the researchers were prohibited from conducting field operations there.

Table 2. List of Rural Barangays, Women's Studies Project, Bukidnon Province, 1996.

1. Basak, Lantapan	12. Pingtauranan, Pangantukan
2. Kibanggay, Lantapan	13. Poblacion, Pangantukan
3. Kawayan, Lantapan	14. Base Camp, Maramag
4. San Luis, Malitbog	15. Dagumba-an, Maramag
5. Pay-as, Kadingilan	16. Dologon, Maramag
6. Panamanggu-an, Kadingilan	17. Kuya, Maramag
7. Salvacion, Kadingilan	18. Poblacion North, Maramag
8. Adtuyon, Pangantukan	19. Poblacion South, Maramag
9. Kimana-it, Pangantukan	20. Bangbang, Kalilangan
10. Langcataon, Pangantukan	21. Malinao, Kalilangan
11. Mendes, Pangantukan	22. Poblacion, Kalilangan

The Ethics Review Board

One of the initial activities encouraged by the Women's Studies Project (WSP) was the creation of the Ethics Review Board. Ours was composed of six members which include an anthropologist, a political scientist and provincial board member of Bukidnon Province, an

educator, a theologian and a cooperative leader, a Department of Health family planning specialist, and a housewife.

The Board reviewed the survey instrument and the FGD questions. They noted that the questions were basically not offensive and these were approved. The Board gave the following guidelines:

a. Respondents and participants should not be forced to respond to questions if they do not wish to respond.

b. Questions in the FGDs should start in an indirect manner and then proceed slowly towards direct questions once the situation permits.

c. The researcher should consider the different possible interpretations of work, rest and leisure with special emphasis on barrio folks who may not have any concept of time as a resource and whose concept of work and rest may be at variance with the Western concept.

d. Sexuality questions should be asked indirectly and any inferences about sexuality should be drawn from the words of FGD participants**.**

The Respondents of the Study

The data were collected from married women 15 - 49 years that are eligible respondents. It was stressed that the women should be the ones to supply the information. No proxy reporting was allowed. Appointments for a callback were made in cases when women were not around at the time of the household visit. As a rule, three attempts were made prior to the decision of dropping the woman as a respondent.

Protection of Respondents

Research ethics demands that we provide protection to our respondents. The importance of the principle of informed consent was emphasized. This includes the assurance of confidentiality, the comprehensive and understandable explanations of the objectives or aims of the study, and the request for voluntary participation.

Oral consent was obtained prior to asking questions during the interview proper and prior to FGD sessions.

Recruitment and Training of Interviewers

Two sets of criteria were evolved in the recruitment of rural and urban interviewers. Although experience in interviewing was given considerable weight, membership in non-government organizations or a women's group were other points considered in the process of selection. Rural interviewers recruited were mostly Barangay Health Workers (BHWs) who are health volunteers and frontline workers in the public health delivery system.

The training was set for one week; the initial session was devoted to gender orientation and gender sensitivity concerns. Topics included gender roles, gender needs and gender expectations, women's status in the Philippines, women's situation and gender/development concerns.

A lengthy discussion was allotted to ethical issues in research to make sure that interviewers understand and would not violate the rights of the respondents. The need to obtain informed consent was repeatedly stressed and interviewers had to respect the rights of respondent to refuse the interview if they did not want to give information.

Activities during the training were all described in the training manual that was first developed in English. However, the Visayan version was the one utilized during the training. The manual contained detailed topics and explanations.

Aside from the investigators, five supervisors facilitated the training. Extensive mock interviews were carried out for every block of questions. The performance of each interviewer was discussed and evaluated daily; weak ones were identified and supervisors focused on their improvement.

During the last day of the training, interviewers were sent to a nearby barangay for mock interviews in the field. It was ascertained that the interviews would last for three hours or more. Thus to avoid respondent's fatigue, the interviewers were instructed not to exceed two hours of continuous interviewing. They should discontinue asking questions if they feel that the respondent is getting tired; an appointment for the next call should be agreed upon to complete the data collection.

The Oral Consent Form, Referral List and Referral Cards

The oral consent form is a part of the survey instrument. It states the objectives of the study, the assurance of confidentiality and the request for voluntary giving of information. The content of the form is read to respondents and the interviewer has to affix her signature in each form.

At the end of the interview, a referral list is given to each interviewed woman; the list contains the names of NGOs, resource persons and professionals who agree to provide services/assistance to respondent in the area of information dissemination/education, counseling, training, cooperative organizing and further referrals to local government units and line agencies.

Together with the referral list, a referral card is provided to respondents. The card introduces the respondents to persons in the referral list. It provides some sort of admittance to potential services and assistance.

To gauge the utility of the referral card and list, the interviewers returned to the sample areas after a three month period and contacted those in the list to check on the number of women who visited them for assistance.

The dismal response in the rural areas led to an inquiry on the reasons why women did not seek assistance. From the interviews of potential providers in the list, the major reason given was that women were too shy to approach people whom they consider authority figures and to seek advice from them. Moreover, women were ashamed to tell of their troubles and problems especially those who are of higher socio-economic status than them. A few urban respondents did visit offices/clinics of those persons in the list. The common assistance sought was related to cooperative loans.

Statistical Analysis and Technique

At the outset, the study was envisioned to be a correlation or association investigation. Using a variety of statistical methods, the analyses would start with the univariate examination of the data. Distributions of single variables are not extensively presented although exploratory analysis of the location, shapes and spread of each variable was made a standard operating procedure. The examination of the frequency distribution was done to determine if there were enough cases for some values of the variables. Information obtained from this procedure will be used later to see if some form of multivariate analysis on the data will produce stable results.

On the basis of models developed for each analysis, bivariate analyses enable the investigator to determine a relationship between two variables. This process weeds out those variables not significantly associated.

The study also conducted multivariate analysis to analyze the data. However, before these techniques are employed, the data are first shown in the form of contingency tables or cross-tabulations. The data are usually tabulated by sex or by area stratum (whether urban or rural). In some cases, they are tabulated according to work categories (whether formal, informal or domestic work) or according to specific methods of contraception. This procedure facilitates comparisons between subgroups and is likely to reveal important relationships between variable categories. In addition, differences between pairs of means are tested through the use of t-tests and ANOVA.

Regression analysis was utilized to determine the impact of family planning use on women's lives especially on such areas as domestic violence, decision-making in the household and task allocation in the household. The investigator made use of the Statistical Package for Social Sciences (SPSS) in the analyses.

Chapter 3

The Findings of the Study

A. Profile of the Sample Household and Women Respondents

Socio-economic Characteristics (Table A1). Variables relating to resources and amenities provide a background picture and lead to better understanding of human behavior. Cross-classification of these variables by community type gives some indications of real differences and pinpoints disadvantaged locales. To begin with, household size, which is an indicator of economic burden, is similar across areas. On the average, households in both Cagayan de Oro and Bukidnon are comprised of six members, a figure slightly higher than the national size of 5.1 (NSO, 1995) .

Relating the size of household membership with income gives us a measure of per capita income, a common indicator of economic well-being. The Social Reform Agenda of Northern Mindanao, 1996-1998 (NEDA, 1994) documented an average monthly income for Bukidnon and Misamis Oriental to be P4,385.00 and P6,616.00 respectively for 1994. These figures compare favorably with the non-depressed areas of Bukidnon and Cagayan de Oro (P4,354.00 and P6,284.00 respectively).

Poverty incidence in the Philippines for the year 1996 is estimated to be 35.5 percent (ISSA, 1996). This represents families who are below the poverty line with an annual per capita income of P 8,885.00. Translated to daily allocation, every person in a family has to spend 24 pesos for "basic food and nonfood requirements."

Poverty incidence in Region 10 is 35.7 percent in 1994 while the annual per capita poverty threshold is P 9,818.00 and P 7,760.00 for urban and rural areas, respectively (NEDA, 1994). This simply means that in urban places a family of six spends 27 pesos a day, while in the rural areas, a family allocates 21 pesos daily.

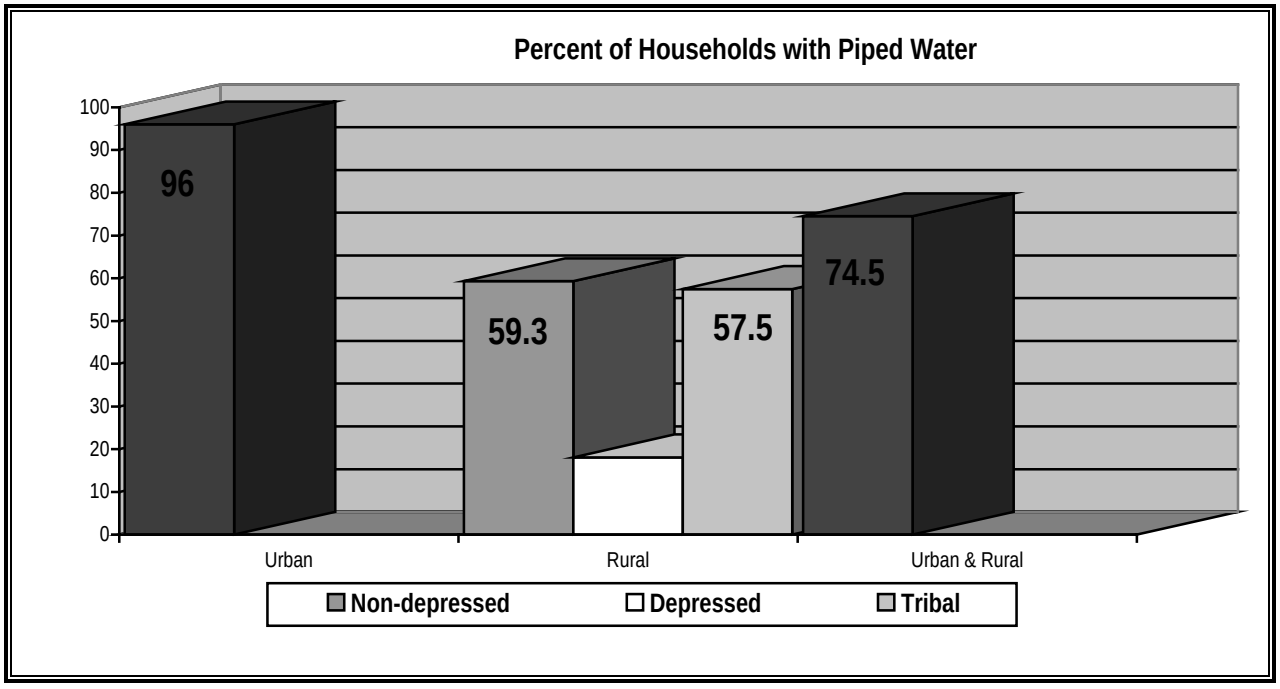
Figures in Table A1 compare favorably with national and regional estimates. However, they also bring to fore the disadvantaged position of depressed and tribal households. Their average income suggests abject poverty, more so if the mean monthly cash income is translated into per capita allocation per day. The amounts of P14.00 and P9.00 for rural depressed and tribal households respectively are indeed too low to satisfy "basic food and nonfood requirements."

The poverty picture may not be that bleak when non-cash income is taken into consideration. In both disadvantaged places (depressed and tribal), eight out of every ten households derive additional non-cash income that is generally more than the reported average cash income. A minimal number of households in Cagayan de Oro City reported obtaining substantial additional non-cash income.

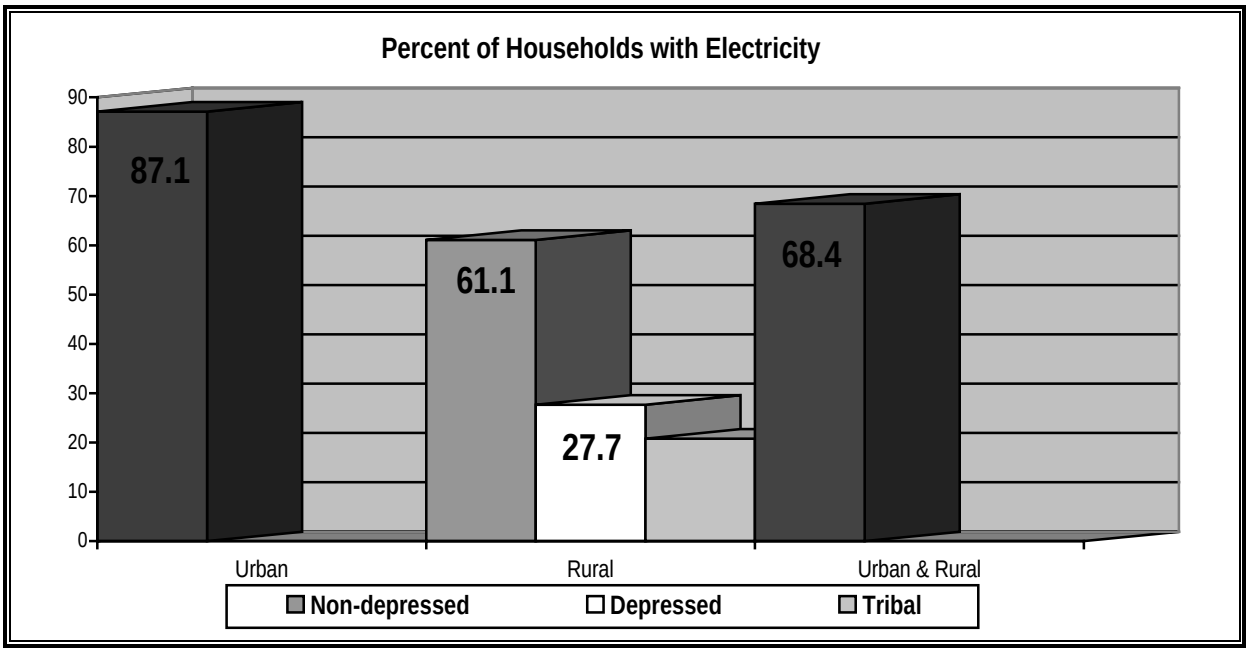
The coping mechanisms for income shortage reported by women during a Focus Group Discussion include the following: wives undertake market work on part-time basis to augment household income, or they resort to credit. Market work consists of vending vegetables and related-farm products, doing laundry, or working in farms for a daily fee. The tight economic condition leads other participants to scrimp on food. Dried fish and vegetables are daily fare. Milk, meat and eggs are luxury items that they can hardly afford.

Data on housing materials indicate preference for dwelling units made of strong material. The majority of households have houses with galvanized iron for roofs, and wood and cement for floors and walls.

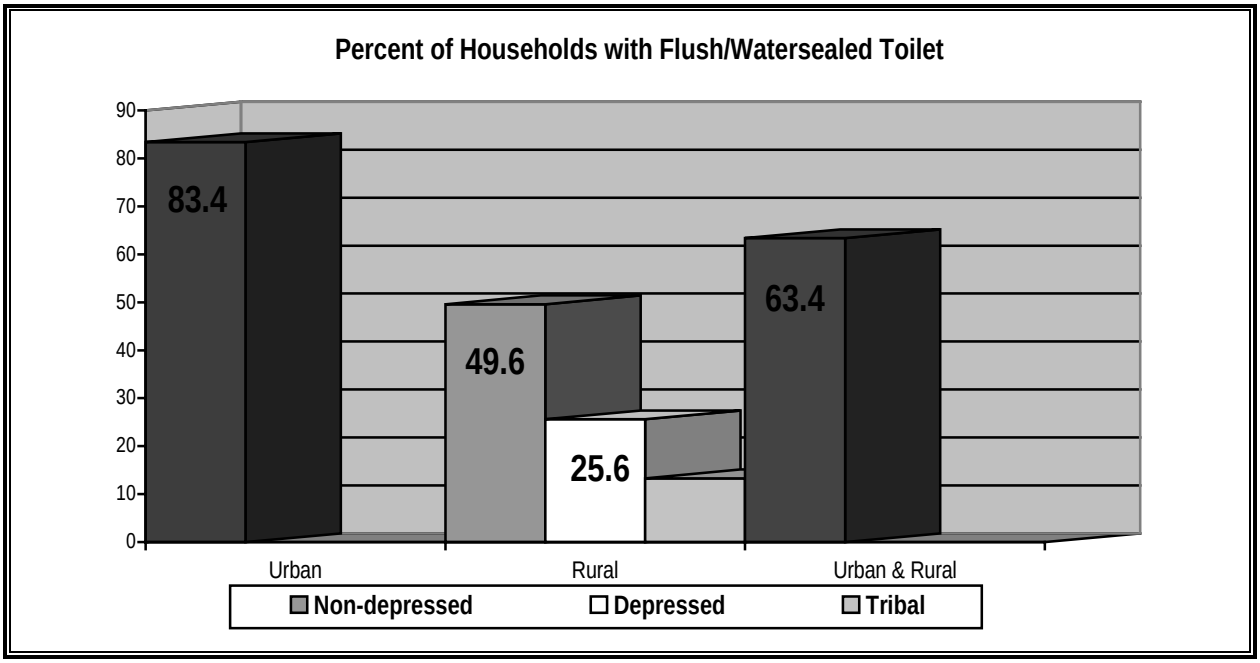
Healthwise, the urban households have an advantage in terms of piped water, electricity, and toilet facilities. These translate to better sanitation and hygiene. The majority of tribal households enjoy piped water. Natural springs are engineered to directly flow from the source to the household. The depressed areas are at a disadvantage; households rely on rain and open wells as sources of water supply.



The national estimate of households without electricity is 34 percent (ISSA, 1996). More than twice these percentage of households in disadvantaged places in Bukidnon are without electricity. While the national estimate compares well with the overall figure, the differential between areas is masked by the national average.



Good toilet facilities are a must for hygiene and sanitation. Again, the pattern is sustained by the data, in particular, the advantaged position of households with water-sealed type of toilets in both Cagayan de Oro and Bukidnon.



Possession of household items, appliances, and other consumer durables is an indicator of socio-economic status. Seventeen items were enumerated, ranging from the most commonly acquired to the most difficult to obtain. The pattern of ownership is consistent with other economic

indicators. The urban and non-depressed households have an advantage over their rural counterparts. More than one-third has expensive consumer durables like television sets, refrigerators, vehicles, etc. Eight out of ten households in the disadvantaged areas boast of owning five which invariably include a transistor radio.

Table A1. Household Variables of Sample Women by Area: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Household Variables	Urban	Rural			Both Rural & Urban
		Non-depressed	Depressed	Tribal	
	n= 1,000	n=270	n=270	n=120	n=1,660
Average household size	5.9	5.9	5.9	6.0	5.9
Average monthly cash income	P6,283.70	P4,353.90	P2,541.10	P1,624.50	P5,018.60
Percent of households with non-cash income	9.1	67.4	86.3	89.2	37.0
Per capita income per month	P1,065.00	P 737.90	P 430.70	P 270.80	P 850.60
Per capita income per day (cash income)	35.5	24.6	14.4	9.0	28.4
Average non-cash income (monthly)	P9,196.40	P4,447.00	P2,467.70	P1,915.40	P6,803.10
Percentage of households with strong housing materials	74.6	81.1	65.2	65.0	73.5
Percentage of households with material posessions					
none	6.2	7.1	4.4	3.4	5.9
1 - 5 items	53.0	58.4	74.5	84.0	59.6
6 - 10 items	39.9	30.0	19.6	11.8	32.9
11 - 17 items	0.9	4.5	1.5	0.8	1.7
Percentage of households with piped water	96.0	59.3	18.1	57.5	74.5
Percentage of households with electricity	87.1	61.1	27.7	20.8	68.4
Percentage of households with flush/ water-sealed toilet	83.4	49.6	25.6	13.3	63.4

The three most common items owned are wall clock, radio, and cassette recorder. Comparing depressed and tribal households, the latter are at a disadvantage especially in the ownership of more expensive consumer durables (Table A2). Looking at these household items from a gender perspective, that is, whether ownership of items satisfies the practical gender needs of a woman, the data show that even in urban places and non-depressed areas, the needs of women are muted by the needs of family members for entertainment. A greater percentage of respondents report owning radio and cassette recorders more than those owning electric irons and refrigerators, items which are deemed to lighten and ease household chores.

Land ownership is an area generally controlled by men. Figures in Table A2 focus on land ownership as indicated by the name in the torrens title. It is evident that husbands have the

greater edge over the wives especially in depressed and tribal areas, although the majority of households reported the names of other owners which include parents and siblings.

Overall, only one-third of sample households confesses to owning land. Ironically a greater majority among tribal households do own land.

Table A2. Percent Distribution of Sample Respondents by Material Possession and Land Ownership: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Household Variables	Urban	Rural			Both Rural & Urban
		Non-depressed	Depressed	Tribal	
Percent reported having:					
wall clock	74.6	57.0	42.2	26.7	63.0
radio	51.1	50.0	68.5	66.7	54.9
cassette	55.3	37.8	21.5	20.0	44.4
TV/VHS	41.8	41.1	17.4	5.8	53.0
electric iron	44.6	25.9	9.6	5.0	33.0
refrigerator	36.2	20.7	8.9	4.2	26.9
Owned land	25.8	37.8	45.2	61.7	33.5
	(n=258)	(n=102)	(n=122)	(n=74)	(n=556)
Name in land title					
husband	26.0	37.3	48.4	44.6	35.4
wife	8.9	3.9	4.1	2.7	6.1
both	8.5	2.9	6.6	0.0	5.9
others	56.6	55.9	41.9	52.7	52.5

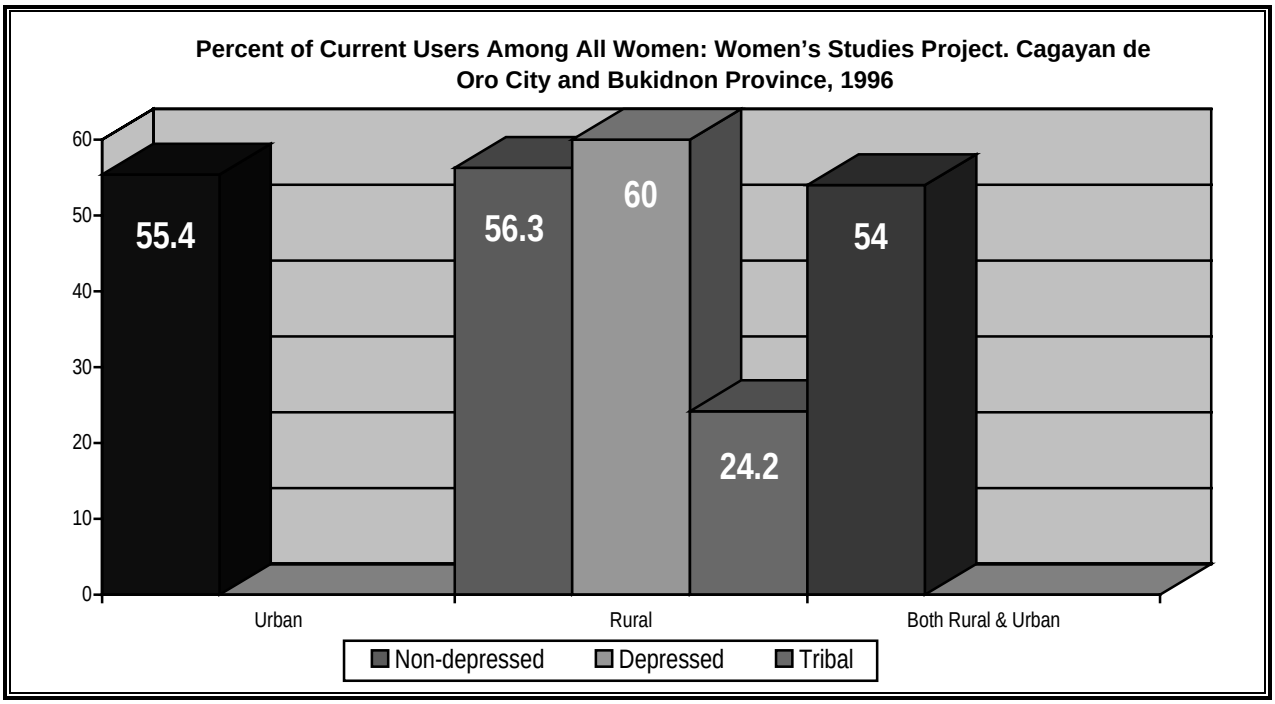
***Family Planning Knowledge and Practices* (*Tables A3 & A4*).** The women respondents, on the average, are in their early thirties. The mean ages across areas range from 31 to 35 years with tribal women registering the youngest average of 31. Age at marriage is 21 years with tribal women marrying slightly earlier than other women in the sample. Eight out of every ten women are Catholic, except the tribal mothers of whom nearly one-third profess non-Catholic affiliation.

On the average, sample women finished third year in the secondary level. Differences in educational attainment are shown by the data. Consistent with other indicators, the respondents from depressed and tribal barangays are four grade levels lower than their urban counterparts.

Contraceptive prevalence of all currently married women is high (54%) compared with the national rate of forty-eight percent (48%) derived by the Family Planning Survey of the National Statistics Office. Across area variation is observed with economically poor barangays exhibiting a highest prevalence rate of sixty percent (60%). Well developed barangays and city areas have rates close to the over-all estimate. Women from tribal communities area are least reached by the FP services if we take prevalence rate as a gauge.

The rural areas (Bukidnon Province) were the same places covered in the 1994 UNICEF-funded study. Comparison of the contraceptive prevalence obtained from the prior study and WSP rates indicates a big leap in family planning use albeit the increase among tribal women is not that dramatic, to wit:

	UNICEF 1994 Study	1997 WSP
Well-developed barangay	**34.2**	**56.5**
Poor barangay	**23.0**	**60.2**
Tribal barangay	**19.4**	**24.2**



The number of users of modern methods is twice as much as the traditional contraceptive users (Table A4). Contrary to most of the family planning studies, which pinpoint the pill as the number one choice, this study reveals that the IUD is the popular contraceptive method. The preference of IUD and tubal ligation indicates that women's choices are dictated by the desire for a method that guarantees effective prevention of pregnancy.

Almost one-third of current users are still practicing traditional methods of contraception which include withdrawal and use of herbs.

Table A3. Percent Distribution of Sample Women by Personal/Social Attributes by Area: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Household Variables	Urban	Rural			Both Rural & Urban
		Non-depressed	Depressed	Tribal	
	n= 992	n=269	n=269	n=120	n=1,650*
Average age of sample women	32.5	34.5	32.9	31.1	32.4
Mean education	11.0	9.2	7.3	6.6	9.6
	(H.S. graduate)	(H.S.-2)	(grade6)	(grade 6)	(H.S. - 3)
Percent with High School education	50.2	44.8	35.2	22.5	44.9
Mean age at marriage	21.1	20.6	19.7	18.9	20.6
Percent Catholic	82.1	85.9	86.3	69.2	82.5
Percent of current users among currently married women	55.8	56.5	60.2	24.2	53.9
Percent of sample women who experienced pregnancy while on FP	25.3	18.9	24.8	12.5	23.2
Percent of sample women who experienced unwanted pregnancies	45.3	47.8	47.8	45.8	46.1

***** excluding non-response

Another indicator, which tells of unmet needs, in reproduction is the percentage of mothers who reported experiencing an unwanted pregnancy. The overall total of forty-six percent (46%) is slightly higher than the 1993 NDS data by two percentage points. From a gender perspective, this result is alarming because this constitutes a substantial number of women who have little control over the decision regarding the number of children to have or when to have them. The unwanted pregnancies may well have been experienced by women prior to family planning acceptance or by never users. Moreover, these may also be the women who want to space or limit their children but have no access to family planning assistance.

Women in the Focus Group Discussions related that generally a pregnancy is unwanted when one has a 3-month baby and is pregnant again. The general consensus on why such occurrence happened is that the couple shunned contraception or misused a method. Others blamed husbands who cannot manage their sexual urges. A few women attributed unwanted pregnancies to the cold climate of Bukidnon which triggers uncontrolled sex between couples.

Tribal men in the post-survey FGD acknowledged that unwanted pregnancy is a problem. A woman participant from cultural community related her attempt to commit suicide because she got pregnant and could not contemplate how to handle it. However, the most common reaction is to accept the fact and allow the child to develop in the womb. Other reasons for acceptance includes: accept the child because it may bring bad luck and it is a sin not to accept the pregnancy.

Two urban husbands related their experiences of unwanted pregnancy. Their wives got pregnant while they were practicing the rhythm method. The health center doctor sent a letter to each husband scolding him. Resentful of the scolding, they went to see the doctor. They were given another lecture on the appropriate rhythm practice and they were thankful for getting the information.

Participants in the Focus Group Discussion tell how they (husband and wife) manage to accept the reality of unwanted pregnancy. The initial response was rejection; poverty is usually the major constraint why an additional child is unacceptable. Women relate that in most instances, it was their husbands who would convince them to accept the reality and not to attempt any efforts that may jeopardize the life of the fetus.

Occurrence of pregnancy while on contraceptive use does not speak well of the method, use patterns, or the delivery of service, particularly, the education component. One in every four currently married women in the urban and depressed sample areas had experienced pregnancy while in current use.

Table A4. Percent Distribution of Currently Married Women By Current Contraceptive Methods: Women's Studies Project. Cagayan de Oro City and Bukidnon Province 1996.

Type of Method	Percentage
All Methods (n=897)	**53.9**
Modern Method	**36.4**
Pill	9.0
IUD	16.4
Injectable (DMPA)	2.0
Condom	1.6
Female voluntary sterilization	6.6
Male voluntary sterilization	0.3
Lactational Amennorhea Method (LAM)	0.5
Traditional Method	**17.5**
Calendar/Rhythm/Periodic Abstinence	13.0
Withdrawal	3.5
Others (herbal, etc.)	1.0

Responsibility in Household Tasks. Activities listed in Table A5 are categorized in terms of stereotyped gender roles. Earning a living and doing repairs in the household are tasks allocated by most wives to the husband. The predominantly wife-related tasks include cooking, laundering, cleaning the house, budgeting, and caring for the children. Fetching the children to and from school is not viewed as a household task either because the children can manage to go to school or the school is within walking distance.

Only one in every five respondents reported elderly care as a current task. The figure indicates several seemingly plausible explanations: elderly people do not pose as a responsibility since they can take care of themselves, the elderly do not live with their married children, or the respondents are still young enough to have relatively young parents.[*]

[*] Average age of respondent was about 31 so parents maybe only in their early 50s.

Gender role is diffused in tasks related to gainful activity, like raising livestock or poultry and gardening. A large percentage of the non-responses constitute urban households with no available backyard.

The community managing role is reflected in the task of attending barangay activities. The concept of public/private divide indicates that involvement in barangay activities is more of a male rather than a female task. However, the actual figures disconfirm the concept; these show greater female involvement in community affairs.

The over-all picture shown by figures in Table A5 provides empirical evidence on the heavy burden of women in the household.

Table A5. Percent Distribution of Sample Women by Task Allocation: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Percent responding on who is responsible for the following activity	Responsible Persons				
	Wife	Husband	Both	Others	No Response/NA
earn a living	0.7	79.0	19.6	0.1	0.5
cooking	83.3	1.7	9.9	4.6	0.5
cleaning and washing after working	78.9	0.8	5.7	14.2	0.4
marketing	75.0	9.5	12.6	2.8	0.3
control of household budget	89.3	5.7	4.7	0.3	0.3
cleaning the house	82.4	0.6	4.2	12.7	0.5
laundry	82.2	0.7	6.4	10.0	0.7
taking care of children	81.8	0.6	11.2	2.6	3.8
care-giver of sick children	58.0	1.6	36.8	0.4	3.1
elderly care	13.0	1.1	5.7	0.8	79.5
accompanying children to school	29.0	4.9	3.5	4.4	58.1
repairs in the house	3.7	84.0	2.2	8.9	1.5
raising livestock/poultry in the backyard	22.8	17.8	18.3	3.3	37.8
gardening	23.6	19.3	12.4	1.9	42.7
attending local/barangay activities	45.3	33.3	15.7	1.7	4.0

Rural women participants in the FGDs believe that household work should be shared especially in instances when either spouse is indisposed. Men from tribal communities, however, believe that household tasks should be the woman's responsibility since husbands are either in the office or in the farm.

On the question of whether the husband can do reproductive tasks, e.g. taking care of the children, both urban and rural women are in accord that it is important for the husband to perform such tasks. Rural women would rather do the household tasks because husbands are generally inefficient especially in cooking and in doing laundry.

Both rural and urban women view reproductive tasks as their obligation. While the husband's responsibility is to provide finances for the family, it is the wife that should do the household tasks. Women recognize the many tasks they perform; the daily hours seem not enough and relaxation remains elusive especially when one has small children. The daily chores sap women's energy, however, they have to do these. As one succinctly puts it, "You may not want to accept them, you may regret getting married but the reality remains that we have to do these tasks."

Urban and rural women who work for pay believe that their husbands realize and appreciate their double burden. Husbands express such appreciation by helping in household chores after their work and by urging children to take over tasks usually done by the wife.

Women's Employment and Control of Resources. Most of the respondents in the study are full-time housewives (75.5%). Only twenty-four percent (24.4%) of the respondents are engaged in market work. The average monthly income of the respondents is P1,184.00 while the average monthly income of their husbands is P3,692.00. The answers given by the respondents indicate that their earnings are used mostly for consumer durables, food, savings and the school needs of their children.

Thirty-one percent (30.9%) of the respondents had known of a loan source in the community while 15.1% had taken out a loan. Of those who had taken a loan, the husband's approval in most cases was needed before the respondent could apply for a loan.

As shown in Table A6, some 70.2% of the 402 respondents who indicated that they were engaged in market work were satisfied with their work. However, the table shows that very few of them enjoy work-related benefits. For instance, only 9.6% have sick leave and vacation leave privileges. Moreover, only 10.1% have maternity leave benefits. The figures in Table A6 indicate that eighty-four percent (84%) of these working women are employed in the informal sector where work-related benefits are not usually part of the compensation package.

These figures indicate that very few women in the study are engaged in market work. And if they are, their working conditions are less than ideal. This suggests that government or concerned sectors should provide women with more employment opportunities so that they would not depend solely on their husbands for financial support. Indeed, the data imply the disadvantaged position of women vis-a-vis their husbands and put to waste a lot of talents since women, on the average, have the same level of education as their husbands and have, on the average, equal skill levels in comparison with their husbands.

Table A6. Women's Employment and Control of Resources Data: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Number of Women	1,660
Percent engaged in domestic work	75.5
Percent working in informal sector	20.7
Percent working in formal sector	3.7
Percent with household help	7.6
Average monthly income of (women) respondents (in pesos)	P1,184.00
Average monthly income of husbands (in pesos)	P3,692.00
Percent of (women) respondents who had known about loan sources in the community	30.9
Percent who had taken out a loan	15.1
Percent who had taken out a (percent/interest) loan	7.3
Percent who indicated that husband's approval was required for them to be able to take out a Loan	13.0

Table A7. Satisfaction with Employment and Benefits from Employment (refers to the 402 respondents who are employed both full-time & part-time): Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Number of Women	402
Percent satisfied with employment	70.2
Percent with sick leave benefits	9.6
Percent with vacation leave benefits	9.6
Percent with maternity leave benefits	10.1
Percent with retirement/pension benefits	6.7
Percent with health insurance benefits	6.7
Percent with life insurance benefits	6.9
Percent with disability insurance benefits	6.2
Percent with child care benefits	2.2
Percent with educational benefits	3.4
Percent with bonuses	11.1
Percent with housing benefits	3.7
Percent with food benefits	1.7
Percent with hazard pay benefits	6.7
Percent with loan benefits	7.9

Women's Participation in Community Activities. Almost all of the women respondents in the study think that it is desirable to participate in community activities. Only five percent (5%) think that it is not good to do so. The reasons given by the women on why participating in community activities is good include the following: 29.9 percent indicated that it will keep them informed about what is happening in the community; twenty-three percent (23%) indicated that participating in community activities will enable them to learn something or to acquire more

personal skills; and 8.9 percent reported that participating in community activities will provide them with an outlet for leisure and enjoyment or teach them how to socialize.

About half of the women (51.1%) said that they had actually participated in a community activity that could be any of the following: church activities (24.8%), community development activities (11.0%), and health-related activities (5.8%).

The data clearly indicate that the women respondents perceive that joining community activities is beneficial. They see it as a means of keeping them informed about community affairs, as a means of educating themselves and learning new skills and as a way of entertaining themselves. Since most of the women in the study are full-time housewives, it appears that participation in community activities gives the women the opportunity to break away from their usual routine of household work.

Summary

A Profile of Sample Households

- A differential in economic condition is observed between areas; tribal and depressed areas of Bukidnon are at a disadvantaged position in terms of:
    - per capita income
    - average monthly cash income
    - material possessions
    - household amenities
- Household ownership of goods indicates gender-bias against women. Practical gender needs of women give way to the need for entertainment. Thus, ownership of a radio, TV, or cassette is preferred more than ownership of an electric iron or a refrigerator.
- Control of a major resource (land ownership) is evidently in the hands of the husband or other relatives.

Profile of Sample Women

- Sample women are, on the average, 32 years old; have attained a third year high school education; married at age 21; and are Catholic. Women from tribal and depressed communities spent fewer years in formal education. They also married younger than their urban counterparts.
- More than one-half (54%) of sample women are currently using a method. There is wide preference for modern methods. The most popular is the IUD followed by the pill and tubal ligation.
- Unwanted pregnancy had occurred to forty-six percent (46%) of the women under study. About a quarter (23%) had experienced a pregnancy while using a family planning method.

- Household tasks are reported by women to be predominantly the wife's tasks. The tasks of earning a living and doing repairs on the house are allocated to the husband. In addition to household work, a greater number of women compared to men attend community activities.
- Only one of every four women is engaged in selling; the rest are full-time housewives.
- If a woman does work for pay, her husband's average monthly income is thrice that of the wife's.
- Three out of ten women have knowledge about loan sources; those who did venture to obtain loans sought the husband's approval first.
- Working women indicated satisfaction in work albeit very few were provided with work benefits. Sick leaves, vacation leaves and maternity leaves were extended to one out of every ten (10) working women only.
- Participation in community affairs is viewed to be beneficial for the following reasons: it keeps them informed, they learn something or they learn personal skills; and it provides a way to spend leisure and enjoy the company of others.
- The majority of women involved in the community mentioned church-related work, community development and health-related activities.

Implications and Recommendations

The findings of the study highlight socio-economic differences and the deprivation of depressed and tribal places in terms of development inputs. Assuming that government resources are scarce, shouldn't households in these areas receive higher priority in the distribution of development benefits? How can they be mobilized to initiate action, which will trigger responses to their immediate needs?

Looking through the gender lens, it is seen that women's practical needs are not satisfied based on the household economic conditions and possessions; these are needs which enhance women's efficiency in the performance of their role. For instance, acquisition of household appliances, which lessen the household burden, usually gives way to acquisition of entertainment items, notably television and radio sets.

Practical needs relative to household amenities are indeed a greatly felt need for women in the depressed areas. An overwhelming majority of these women live in households with no piped water. This implies that water has to be fetched often from some distance. Even if other members of the family do this task, the portability and safety of water is questionable and thus may lead to a higher incidence of diseases.

National statistics and estimates provide a picture that hides or conceals differences. For instance, in the area of education, a high literacy rate and high female college enrollment are observed for the entire country. The average educational attainment of sample women in the study areas is third year high school. However, women from tribal and depressed areas have four grade levels less than the average.

The contraceptive prevalence rate of sample women is favorable compared with the national figures. The contraceptive prevalence rate in Bukidnon speaks well of the efforts to reach

depressed areas. It is mainly in the tribal communities that health service delivery in family planning has to be improved.

Unwanted pregnancy is high. This phenomenon has not only economic implications but has social and moral ramifications.

Considering the implications of study results, the recommendations given here may lack specificity, albeit the thrust, coverage and the focus are present:

- Development efforts should reach out to disadvantaged places and households. Better roads, electricity, and availability of transportation may translate to improvements in women's economic condition. The extremely poor roads make transporting products and persons an expensive endeavor. The peace and order situation exacerbates their disadvantaged position.
- In what ways can disadvantaged households claim development assistance, more so, in a political setting where prioritization of development programs are determined by the number of votes that can be obtained rather than the immediate felt need?
- The non-government organizations (NGOs) and religious groups have to initiate and mobilize residents to advocate action on their needs. This presupposes prior goal-setting among residents and an assessment of their constraints. Advocacy work of NGOs must implement better and efficient information-dissemination strategies, so that the plans and course of action decided upon by residents are grounded on accurate information.
- Differentials in practical gender needs should be taken into consideration in the planning of local government units (LGUs). In what ways can gender concerns be mainstreamed in government planning? The women's groups on the local level should focus on ways and strategies by which they can influence planners to integrate the practical gender needs of women. What if the depressed areas or tribal communities have no women's groups strong enough to influence local officials? The urban-based women's organizations then have to reach out and network with fledging, loosely-organized women's groups and impart to them knowledge, skills, and strategies by which their voices can be heard and can make a dent in an otherwise dominant male enclave. Moreover, efforts should be addressed both too practical and strategic gender needs.
- It is imperative that all sectors of society join hands and work together. More consciousness-raising activities have to be done, reaching out to men and children. Sustained efforts for information, education and communication can be attained through networking.

B. Family Planning Use: Making A Difference on Women's Reproductive Health

Family planning use is influenced by factors, which include among others, women's personal attributes, family characteristics as well as the prevailing social and political conditions in which women live. Studies identified cultural norms and religion as important deterrent to adoption of a contraceptive method. These determinants explain influences to couple's decision or woman's decision on the use or non-use of contraception. The understanding of these factors may lead the

development of new strategies (including provision of various contraceptive methods) which are culturally-sensitive, user-friendly, and politically acceptable.

On the other hand, use of family planning has its consequence on the lives of women, directly and indirectly. The indirect results flow from women's realized or unrealized reproductive goals, which in most cases mean smaller family size and larger birth intervals.

This paper looks at the state of family planning use or non-use as it impinges upon women's reproductive health. Specifically this section aims:

1) To present the differentials between family planning users and non-users in terms of social, demographic, and economic variables; and

2) To describe women's strategic and practical reproductive needs.

Strategic and practical needs are differentiation brought about by gender relation. The latter refers to needs identified by men and women arising out of the customary division of labor. Meeting and satisfying practical gender needs make the performance of reproductive roles easy and effective.

Needs that emphasize the subordination of women are referred as strategic needs. To satisfy them demands structural change, which involves creation of social interventions to alter existing policies, practices, and norms that encourage or perpetuate the subordinate position of women.

Applying this differentiation in reproductive health and relating to family planning use provides a wider and deeper understanding of women's concerns. Since family planning is the core to pursue reproductive health (Danguilan, 1994), analysis of these strategic and practical needs may set direction in advocacy and service delivery.

Practical reproductive needs are operationalized in terms of knowledge of family planning education (need for information-education), reproductive health services received and would like to receive (need for reproductive health services), experiences with family planning providers (quality of care), and other indicators of practical and strategic needs like unwanted pregnancy and infertility.

Description and articulation of strategic reproductive needs hinge upon the identification of practical reproductive concerns. The two types of needs are so intertwined that one cannot be divorced from the other.

This paper uncovers the practical reproductive needs and stresses the strategic ones under the rubric of implications and recommendations.

Moreover, the analysis lays no claim on measuring reproductive health needs by assessing whether or not a woman's reproductive need requirements are met. Having no standard as reference, the analysis focuses on differences between contraceptive use status.

The framework of analysis is lifted from the four pillars of reproductive health awareness (RHA) (Diaz, 1997; Marshal M., V. Jennings and Cochran, 1997). Although RHA is an educational approach, and deals mainly on awareness, its applicability to data analysis strengthens the advocacy thrust of this study. Introducing a modification by integrating practices related to use and non-use of contraception lends depth to the approach as it is applied to data analysis.

The four pillars of reproductive health awareness include: body awareness; gender awareness; integration of sexuality and interpersonal communication. Going beyond mere care and respect of our bodies, body awareness covers how we view sexuality, fertility awareness, preventive health practices and avoidance of high risk behavior.

Gender awareness, on the other hand, revolves around subjects like how men and women are valued, domestic violence, and practices that are unfair, dangerous and limiting.

Integration of sexuality refers to awareness of people with regard to sexuality expression and sexual norms while interpersonal communication includes decision-making in the households.

This paper focuses on the fertility awareness and practices as a core element to the pursuit of reproductive health. While we recognize the importance of not taking each of the pillar independently, the analytical nature of its application here provides a justification for treating one pillar as an independent component.

Differentials in Family Planning Use

Status of Use. The contraceptive prevalence rate of fifty-four percent (54%) for currently married women in the WSP areas compares favorably with the national estimates (48.1%) derived from the 1996 Family Planning Survey of the National Statistics Office (NSO).

Differences over time and by different studies a show trend in contraceptive prevalence for currently married women, to wit:

Philippines	**Contraceptive Prevalence**
• 1995 FP Survey, NSO	50.7
• 1996 FP Survey, NSO	48.1
Cagayan de Oro	
• 1997 LPP - Multi-Indicator Cluster Survey	69.3
Bukidnon	
• 1997 LPP - Multi-Indicator Cluster Survey	63.7
WSP 1996 Cagayan de Oro	53.9
WSP 1996 Bukidnon	
• Non-depressed	56.3
• Depressed	60.0
• Tribal	24.2

The WSP estimates, while definitely lower than the Local Government Unit Performance Program Multi-Indicator Cluster Survey (LPP-MICS) figures, provide differences by area which yield programmatic implications. For instance, family planning personnel can focus efforts and service delivery on tribal communities as priority areas. Evidently, past efforts were concentrated on depressed places.

Nearly one in every four of sample women (Table B1) confirmed never having used contraceptive methods. One-fourth experienced use but are currently non-contraceptive users.

To establish whether or not never users married later than the ever-users, the average duration of marriage was derived from the data. Indeed the never users have less years spent in marital state (11 years compared with 12 years of current users) albeit the gap is not big enough.

Adoption of family planning methods may last for only a few days as suggested by the data. It appears that for these women the decision to use a contraceptive method is short-lived. Moreover, duration of use of current non-users differs considerably with the current users. Average duration of use of latter is twice as much as those who have stopped.

On the average, urban ever users practiced family planning for six years; their counterpart from rural non-depressed areas reported 3 years duration of Family Planning use.

Table B1. Family Planning Practices of Currently Married Women by Status of Use: Women Studies Project. Cagayan de Oro City and Bukidnon Province, 1996

	All Currently Married Women n=1650*	Never Users	Current Non-users	Current Users	
		402	358	890	
Family planning Status (in percent)	**100.0**	**24.4**	**21.7**	**53.9**	
	All Women	**Never users**	**Current Non-users**	**Current Users**	
Average Duration of marriage	11.7	10.7	12.7	11.8	
	Ever Users	**0 months**	**less than 5 years**	**5 - 10 years**	**over 10 years**
Duration of Use (in percent)	100.0	22.8	46.1	20.2	10.9
	All Ever Users n = 1,248		**Current Non-users**	**Current Users**	**No Response**
Average Duration of Use (in months) of ever users	43.9		33.4	63.3	2.1
	All Ever Users	**Urban**	**Non-Depressed**	**Depressed**	**Tribal**
Average Duration of (in months) Use by Area	64.0	77.1	37.5	50.7	43.6

10 cases have missing values

Economic Characteristics by Status of Use. Differences between FP users and non-users were examined relative to economic indicators.

Figures in Table B2 provide evidence of the disadvantaged economic positions of never users. Although they had smaller family size, economic indicators show that never users live in houses with light materials, have small number of material possessions, have lower average income in comparison with the ever users.

The average monthly income is translated into per capita monthly allocation by dividing the income figures with the average household size. For national and international comparability, the monthly per capita was converted into an annual estimate.

The poverty threshold (annual per capita income) in the Philippines in 1996 is pegged at P8,885.00 (ISSA, 1995). This is way below the international standard which defined absolute poverty as those with per capita income of 370 dollars per year (PAI, 1997). Translating this to the Philippine currency (at a rate of $1 = P35), this means an annual income of P12,950.00 and an individual can spend thirty-five pesos (P35) daily for basic minimum requirements. An average Filipino from a household of six members has a daily allocation of 24 pesos. Given the current prices of basic commodities, this amount is definitely not enough for basic food and nonfood requirements.

Significant differences between use category and average monthly income is shown by the data with the never users' household incomes below par compared with the ever users.

The data suggest a better economic condition of current users. They have better houses, higher number of consumer durables, and higher average income. Comparison of current users and non-users also indicates economic advantage of the former.

Table B2. Economic Characteristics by Status of Family Planning: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996

	Family Planning Status			
	All Women	Never Users	Current Non-users	Current Users
Economic Variables				
Number of women	1,650	402	358	890
Household size	5.7	5.2	6.1	5.8
F - Value = 18.9168 P -level = .000				
Housing Material Index	5.7	5.5	5.7	5.8
F - Value = 7.3962 P -level = .000				
Material Possession Index	4.4	3.9	4.3	4.7
F - Value = 9.0802 P -level = .000				
Average Monthly Income	P4,669.00	P3,871.70	P4,631.00	P4,977.20
F - Value = 6.3472 P -level = .001				
Average Per Capita Monthly Income	P819.00	P744.60	P759.00	P858.00
	Duration of Use (Ever Users)			
	Total	less than 5 years	5 - 10 years	More than 10 years
Number of Women	1,650	801	301	146
Household size	5.9	5.8	6.1	6.2
F - Value = 5.771 P -level = .003				
Monthly Income	P4,934.00	P4,297.00	P5,896.00	P6,434.00
F - Value = 19.5748 P -level = .000				
Housing Material Index	5.7	5.7	5.9	5.9
F - Value = 10.1451 P -level = .000				
Material Possession Index	4.4	4.2	5.5	5.5
F - Value = 28.6790 P -level = .000				

Socio-Demographic Characteristics and Status of Use (Table B3). Significant differences exist between family planning use or non-use and age of women, age at marriage, education, and hours spent on household work.

Current non-users are slightly older than their two counterparts although no difference is seen in their age at marriage. In terms of education, current users are better-educated and spend less hours in household tasks.

The over-all pattern indicates that never users are slightly younger, have less educational attainment and spend more hours in household work compared with the ever-users when focusing on ever users only, and evaluating differences by age, age at marriage, education, and daily hours spent on domestic work, a similar pattern is revealed as shown by Table B3. Women with shorter duration of use are younger, less educated and spend longer hours in domestic work.

Table B3. Socio-Demographic Attributes of Women by Status of Family Planning: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996

Demographic Variables	Family Planning Status			
	All Women	Never Users	Current Non-users	Current Users
Number of women	1,650*	40	358	890
Mean age of women	32.4	31.5	33.3	32.4
F - Value = 6.1495 P -level = .002				
Average age at first marriage	20.7	20.8	20.5	20.6
F - Value = .2071 P -level = n.s.				
Average educational attainment	9.6 (H.S. 3)	8.7 (H.S. 2)	9.5 (H.S. 3)	10.1 (H.S. 3)
F - Value = 16.2186 P -level = .000				
Average daily hours spent on household work	6.0	6.3	6.2	5.8
F - Value = 3.4606 P -level = >.05				
	Duration of Use			
	Total	less than 5 years	5 - 10 years	More than 10 years
Number of women	1,248	801	301	146
Average age of women	32.4	30.5	35.2	37.4
F - Value = 67.64 P -level = .000				
Age at first marriage	20.6	20.6	20.7	20.3
F - Value = .4630 P -level = n.s.				
Education of women	9.9	9.8	10.2	10.2
F - Value = 2.0975 P -level = n.s.				
Average daily hours spent on household work	6.0	6.5	5.3	4.6
F - Value = 22.1003 P -level = .000				

* 10 cases excluded (missing values)

Irrespective of family planning use or non-use, women have high satisfaction in life (Table B4). No variation related to contraception is observed. An overwhelming majority of women affirmed high satisfaction with their marriage, with the friends that they have, and with their religious life. However, dissatisfaction is voiced relative to their jobs, their current lifestyle and house, and their children.

Table B4. Percent Distribution of Currently Married Women by Family Planning Status and by Satisfaction Index: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996

	All Women	Never Users	Current Non-users	Current Users	P-level
Percent Distribution of all women		326	434	890	
Percent of women affirming satisfaction on the following aspects of life:					
life as a whole	81.6	83.7	80.1	82.0	n.s.
health	85.7	88.5	86.7	85.2	n.s.
leisure/recreation	86.7	87.4	87.6	86.4	n.s.
marriage	93.8	93.8	92.8	95.2	n.s.
children	76.9	77.4	76.6	76.9	n.s.
job	68.0	66.5	65.5	69.8	n.s.
house/lifestyle	72.1	73.4	71.1	72.1	n.s.
neighborhood and community	86.5	88.3	85.9	86.1	n.s.
friends	93.5	93.3	93.8	93.4	n.s.
religious life	92.0	93.2	91.3	91.9	n.s.
Index of Satisfaction	9.3	9.4	9.3	9.3	n.s.
F-value = .1852 P-level = n.s.					

Practical and Strategic Reproductive Needs

As mentioned earlier, reproductive needs are operationalized in terms of knowledge of family planning (need for information, education and communication), reproductive health services (reproductive health services needed and demanded) and, experiences of unwanted pregnancy and infertility.

Contraceptive Knowledge (Table B5). The definition of reproductive health covers a plethora of concerns. Among others is providing informed choices on fertility regulation. However, the ability to choose and use a safe and appropriate method hinges upon the woman's knowledge of the various family planning methods.

The inquiry to determine the level of women's knowledge was conducted in such a way that spontaneous responses were drawn out from the women without interference bias from the interviews. After giving their uncontaminated replies, women were asked "probe" questions mentioning a particular method.

Regardless of family planning status, women have a very high knowledge on the pill, IUD, condom, and tubal ligation. However, awareness on injectables, tubal ligation, and vasectomy is not spontaneous. Methods like the diaphragm, foam, jelly, and withdrawal register low awareness among women.

Table B5. Percent Distribution of Currently Married Women By Contraceptive Knowledge of FP Methods: Women's Studies Project. Cagayan de Oro City and Bukidnon Province 1996.

Percent with knowledge of:	Spontaneous	Prompted	Total
Modern Method			
Pill	90.4	8.4	98.8
IUD	84.9	13.4	98.3
Injectable (DMPA)	36.7	40.1	76.1
Condom	62.2	34.7	96.9
Tubal ligation	45.5	50.0	95.5
Vasectomy	30.3	58.1	88.4
Modern Natural Family Planning	12.9	22.6	35.5
Lactational Amennorhea Method (LAM)	9.9	41.1	51.0
Traditional Method			
Calendar	13.4	37.2	50.6
Rhythm	62.1	31.3	93.4
Withdrawal	5.4	15.8	21.2
Herbal	36.1	50.3	86.4
Diaphragm	3.5	15.3	18.8
Foam/jelly	5.1	18.1	23.2

Comparison of the knowledge pattern by use category reveals the advantage of ever users over those women who had never used a family planning method. Moreover, users have knowledge of both modern and traditional types of contraception. For instance, only two-thirds of never users know about injectables. Poor knowhow on LAM and modern natural family planning is true to both never and ever users.

Among the traditional methods, calendar and withdrawal are most known by women. The pattern of knowledge holds true; a greater percentage of ever users indicated knowing specific traditional methods compared with their never users counterpart.

Table B6. Family Planning Knowledge of Currently Married Women by FP Status: Women's Studies Project. Cagayan de Oro City and Bukidnon Province 1996.

	All Women	Never Users	Current Non-users	Current Users
Modern Methods				
Pill	99.0	96.8	100.0	99.6
IUD	98.5	96.3	98.9	99.3
Injectables	77.0	66.4	78.5	81.1
Condom	97.0	93.0	99.2	98.0
Tubal Ligation	95.6	92.3	96.6	96.7
Vasectomy	88.5	80.6	89.9	91.6
Modern Natural Family Planning	21.2	19.6	16.5	23.8
Lactational Amenorrhea Method	48.4	42.0	50.6	55.1
Traditional Methods				
Calendar	93.6	83.6	96.9	96.7
Rhythm	50.5	41.3	47.8	55.8
Withdrawal	86.6	76.1	89.4	90.2
Herbal	35.2	25.8	40.8	37.1
Diaphragm	18.7	16.9	17.3	20.1
Foam/Jelly	23.2	19.9	22.9	24.7

Knowledge on Reproductive Health. A question on what constitutes reproductive health was asked to draw from women what they think of the term "reproductive health." An affirmation or negations of enumerated reproductive coverage items were elicited from respondents. Figures on Table B7 indicated high knowledge on what constitutes reproductive health. An almost unanimous affirmation was given to "ability to bear children," "ability to choose the number of children to have," and for reproductive health to include "physical and mental well-being." The data, however, show a small percent of women who do not consider "ability to have satisfying sex" to fall under the rubric of reproductive health.

Table B7. Percent Distribution of Currently Married Women by Family Planning Status by Status of : Reproductive Health Women's Studies Project. Cagayan de Oro City and Bukidnon Province 1996.

	All Women	Never Users	Current Non-users	Current Users
Knowledge of Reproductive Health	1,650	402	358	890
Percent saying yes to that reproductive health is…				
a) ability to bear children	93.4	94.3	94.4	93.7
b) ability to choose the number of children	95.6	93.3	96.4	96.4
c) ability to have satisfying sex life	85.1	84.1	83.5	86.8
d) physical and mental well-being	91.3	88.1	91.6	92.6

Difficulty in Conception and Unwanted Pregnancy (Table B8). Reproductive health also means the capability to reproduce and freedom to decide if, when, and how often to do so. In this context, infertility and unwanted pregnancy are concerns with implication on practical and strategic reproductive needs. Across family planning statuses, close to one-third of never-users had difficulty in conceiving. In comparison, one in every four current non-users professed to difficulty in getting pregnant. Only a small percentage (11%) of current users had that problem.

Combining the percent of never-users and the current non-users who have difficulty to conceive there is an indication that infertility is indeed a problem. Among those who experienced difficult conception, nearly one-half of all sample women affirmed that they cannot bear children primarily because of voluntary infertility.

However, differences are noted across use-categories:

- Over one-fourth of never users who have difficult conception cannot bear children mainly because they have reached the end of their reproductive years.
- One in every three current non-users with problem in conception cannot expect to bear a child primarily because they are now in the menopausal stage.
- Current users cannot bear children because they submitted to sterilization, thus, they made a choice for voluntary infertility.

Unwanted pregnancies are experienced by a considerable percentage of women especially the ever-users. One in every three never-users had at least given birth to an unwanted child. Majority of ever-users did experience getting pregnant at a time when they were not ready.

A cursory examination showed three out of every ten women experienced unwanted pregnancies more than once. How do women and their spouses react to the event? The overwhelming response indicated by the data and by the FGDs suggests an interplay between ethics of responsibility and ethics of conviction (Freund, 1964). The decision to keep the child, to allow it to grow full term demonstrates the couple's sense of obligation, what they deem their duty with or without regard to the consequences. The value orientation predominates over goal orientation.

Table B8. Indicators of Infertility and Unwanted Pregnancy by Family Planning Use/Non-use: Women's Studies Project. Cagayan de Oro City and Bukidnon Province 1996.

	All Women	Never Users	Current Non-users	Current Users
Number of women	1,650	402	358	890
Percent of women who had difficulty in conceiving	18.7	30.8	25.2	11.2
Percent of women who cannot bear children	7.8	6.7	8.2	8.0
Reasons why cannot bear children				
post menopausal	2.4	4.5	6.4	---
involuntary infertility (ovary removed, health problem)	1.0	2.2	2.5	0.2
voluntary infertility (sterilized)	4.4	----	----	7.6
Percent of Women experiencing unwanted pregnancy	46.1	30.6	54.7	49.8
n =	(762)	(123)	(196)	(443)
Percent of women who decided to let the child develop full term	90.4	94.3	83.7	92.3
Percent of women who believed unwanted pregnancy has effect on their lives	19.6	20.3	18.9	19.6
Perceived effects of unwanted pregnancy				
anger/blaming spouse/clash with spouse		44.0	43.2	44.8
economic difficulties		28.0	32.4	21.8
psychological/health effects on child		8.0	5.4	10.3
psychological/domestic effect on mothers		20.0	16.2	21.8
No response		---	2.7	1.2
Total		100.0	100.0	100.0

Another response to unwanted pregnancy is to have a miscarriage or an abortion. The data suggest that current non-users may have resorted to this type of action.

Among women who experienced unwanted pregnancy one-fifth believed that the event yielded effects. The most common immediate response is display of anger triggered by the occurrence of the unwanted event. As a consequence, the woman blamed the spouse, a quarrel between the couple ensued, and resentment prevailed. These reactions are true to all categories of family planning use. Economic difficulties ranked second among the effects mentioned. Women reported experiences of financial difficulty and of increasing expenses. Psychological effects on mothers include perceived or real health problems. Anxiety, worry, being scared, and loss of weight are enumerated effects. Mothers realized too the consequences on domestic activities; the unwanted child increased the domestic burden.

The data indicate that effects on being unwanted to the child were not given much consideration by women respondents.

Reproductive Services Received and Needed (Table B9). The figures in Table B9 are revealing in so far as availability and utilization of services are concerned. The Maternal and Child Health care approach has made inroads service utilization. Across the use-category, women reported

having received services connected with prenatal care, child health care, and nutrition counseling. Eight out of every 10 mothers did submit themselves to prenatal services during their pregnancies albeit one-half neglected the after birth check-ups.

Services for reproductive tract infections (examination and treatment) are indeed very poor as indicated by very low utilization of sample women. Other reproductive services, notably the pap smear and pelvic exam were received by only a few women.

The over-all pattern indicated that never users are the least likely to receive these enumerated services except infertility treatment. The current users, it seem have the advantage over the others.

Table B9. Percent Distribution of Married Women By Reproductive Health Services Received, Women's Studies Project. Cagayan de Oro City and Bukidnon Province 1996.

	All Women	Never Users	Current Non-users	Current Users
Number of women	1,650	402	358	890
Percent of women reporting to have received:				
pap smear	8.8	4.5	9.2	10.6
blood test	44.9	42.8	45.2	45.7
breast exam	15.4	8.0	14.8	19.1
pelvic exam	9.8	6.7	10.3	11.0
RTI/STD exam	1.9	1.2	1.4	2.5
RTI/STD treatment	2.4	2.2	1.4	2.8
infertility counseling	44.4	22.0	48.3	53.0
infertility treatment	14.3	17.2	12.3	13.8
prenatal care	81.6	73.6	87.2	82.9
postnatal care	39.9	29.6	38.0	45.3
nutrition counseling	54.9	48.0	55.3	57.9
child health care	66.4	58.0	67.3	69.9

A follow-up inquiry on whether or not they would like to receive such services yields an interesting picture. The pattern reveals a bigger majority wanting services like pap smear, blood test, breast exam, pelvic exam, and RTI examination and treatment. Maternal and child health care is definitely less desired by two-thirds of the women although the postnatal care is claimed to be what they want to receive.

The three most popular services which women would like to receive are pelvic and breast examination and pap smear. The three less desired services are prenatal care, infertility treatment, and child health care.

The pattern holds true regardless of family planning use or non-use.

Table B10. Percent Distribution of Currently Married Women by Reproductive Health Services They Want To Receive, Women's Studies Project. Cagayan de Oro City and Bukidnon Province 1996.

	All Women	Never Users	Current Non-users	Current Users
Number of women	1,650	402	358	890
Percent of women wanting to receive the following services:				
pap smear	73.6	68.4	74.0	75.8
blood test	50.8	51.0	52.5	50.1
breast exam	73.2	74.1	76.3	71.5
pelvic exam	75.6	72.9	77.1	76.3
RTI/STD exam	61.2	53.5	60.6	64.9
RTI/STD treatment	57.8	50.5	57.0	61.3
infertility counseling	34.6	41.0	35.2	31.5
infertility treatment	25.9	29.3	26.8	23.9
prenatal care	11.6	17.9	7.2	10.6
postnatal care	41.3	49.8	43.0	36.7
nutrition counseling	32.2	12.5	33.2	28.8
child health care	23.6	31.3	22.9	20.4

Experiences on FP Services and Desired Quality of Care. To derive information on women's experience when they avail of family planning services, a series of questions were asked on ever users only.

A greater majority of ever users (73%) obtained services from the public sector invariably the health centers. Of those who had been catered by the private sector, the common providers are the private hospital and doctors. Friends and relatives were also sources of family planning services.

Four in every five ever users reported encountering no problem in their recent availment of FP services. Only a small proportion admitted having problems; the three most mentioned are shortage of supplies, clinic/source is far from their homes, and long waiting time.

Only one in every five current users and non-users had experienced ever switching from one method to another. Reasons seem to jibe with problems documented with recent FP availment, namely: source/clinic far from house, source did not offer many services, and long waiting hours.

Table B11. Family Planning Services and Desired Quality of Care Indicators (Ever Users Only) Women's Studies Project. Cagayan de Oro City and Bukidnon Province 1996.

Indicators	All Ever Users	Current Non-users	Current Users
	n =1,248	358	890
Source of Family Planning Services Ever Used			
public sector	73.4	71.2	74.3
private sector	12.5	12.6	12.5
other private sector	13.5	15.1	12.9
no response	0.6	1.1	0.3
Experienced problems with recent Family Planning services?			
no problem	83.4	80.4	84.6
with problem	5.8	6.1	5.6
no response	10.8	13.5	9.8
Percent who ever switch from one type of FP method to another	22.4	17.5	24.3
	Never Users	**Current Non-users**	**Current Users**
Ranking of most mentioned characteristics of FP services considered important			
friendly staff	Rank 1	Rank 1	Rank 1
clean	Rank 2	Rank 2	Rank 2
close to home	Rank 3		
competent staff		Rank 3	Rank 3
Three most mentioned suggestions on how FP services be suited to their needs			
clinic closer to home	Rank 1	Rank 1	Rank 1
more information	Rank 2	Rank 2	Rank 2
longer clinic hours	Rank 3		Rank 3
less expensive		Rank 3	

Regardless of family planning status, women were asked to rank in the order of importance, characteristics of family planning services. Respondents were unanimous to rate "friendly staff" as the most important desirable in dispensing services, as well as "clean" clinic. Ever users ranked "competent staff" as the third important characteristic while never users preferred the clinic to be nearby so they can readily avail of services.

Responses to the question eliciting suggestions on how to make family planning services more suited to women's needs, yielded similar answers. Majority of the women preferred that the clinic be closer to their residence thereby enhancing the availability of access. A provision of more information is one of the striking suggestions; this implies the need for more IEC materials. Never users and current users deplored the fact that family planning services offer short clinic hours; they wished for a longer time. Current non-users lamented the expenses they incurred in availing of family planning services; they suggested inexpensive services. Considering that ever

users generally derived free services and supplies from public health centers, the expense here may be insubstantial compared to others but "expensive" for these women for whom "every centavo counts."

In a desire to uncover whether or not women would prefer a male or a female service provider, a question was posed gauging the acceptability of a male provider.

Figures in Table B12 indicate an overwhelming majority of respondents' preference for a female service provider to perform breast exam, pelvic exam, pap smear, IUD insertions, and STD diagnosis. Tolerance for male provider is expressed with regards to injection. Across use-category the pattern is similar.

Women were also questioned if they would refuse to utilize family planning services dispensed by male providers. Majority affirmed their refusal on services like breast exam, pelvic exam, pap smear, IUD insertion, and STD diagnosis. Two in every three women can tolerate male provider giving injections and a greater proportion would submit to family planning counseling.

Table B12. Percent Distribution of Currently Married Women By Preference of Family Planning Service Providers, Women's Studies Project. Cagayan de Oro City and Bukidnon Province 1996.

	All Women	Never Users	Current Non-users	Current Users
Number of women	1,650	402	358	890
Percent saying female service provider is important on				
Counseling	69.8	67.9	71.0	
breast exam	89.5	91.3	89.2	
pelvic exam	87.8	90.3	87.4	
pap smear	91.5	92.5	91.5	
injection	59.8	59.2	60.7	
IUD insertion	91.1	89.1	91.8	
STD diagnosis	81.1	81.6	81.5	
Percent reporting to refuse services if given by male providers				
Counseling	29.3	29.6	29.3	29.1
breast exam	53.8	54.0	55.0	53.3
pelvic exam	51.3	49.8	53.6	51.1
pap smear	60.1	57.0	62.3	60.7
injection	32.1	32.1	29.3	33.3
IUD insertion	61.6	59.2	63.4	61.9
STD diagnosis	51.1	50.5	50.8	51.5

Conclusion

Does family planning make a difference in women's lives? The findings indicate significant differences in demographic and economic attributes between never users and ever users, to wit:

- Never users live in houses with light materials, have smaller number of material possessions, and have lower average income compared with the ever users.
- Never users are slightly younger, have lesser years of schooling, and spend more hours in household work.
- Current users have better economic condition, they live in houses with strong materials, possess more items of consumer durables, and have higher average income.
- Irrespective of family planning use or non-use, women have high satisfaction in life. High satisfaction is expressed in relation to their marriage, friends, and religion.

Indicators of practical and strategic reproductive health needs are drawn from contraceptive and reproductive health knowledge (need for information-education), experiences of infertility and unwanted pregnancy, reproductive health services received and would like to receive (need for reproductive health services), and experiences with family planning health providers (quality of care).

- Overall, knowledge of different family planning methods is high except for modern natural family planning, withdrawal, and use of diaphragm and foam.
- Knowledge of family planning method is not spontaneous; women have to be prompted in method identification.
- Current users are more knowledgeable about family planning methods compared with the other two use-categories.
- An overwhelming majority of women relate reproductive health to the ability to bear children, the ability to choose the number of children, and physical and mental well-being. Few women do not consider "the ability to have satisfying sex" as falling under reproductive health.
- Close to one-third (31%) of never users have difficulty in conceiving; a lower percentage (11%) of current users professed the same difficulty.

Among those who have difficulty in conception:

- ♦ one of every six never users cannot bear children primarily because they have reached the end of their reproductive period; and
- ♦ one out of three current non-users cannot have a child because of voluntary infertility

- Overall, forty-six percent (46%) of women experienced unwanted pregnancy. However, variation between use-category is shown by the data. Never users have the least number of unwanted pregnancy while current non-users have the highest. The most common response is to accept the reality and let the child grow up to full-term.

- One in every five mothers believed that the unwanted pregnancy has an effect in their lives, most notably stressful relations with husbands characterized by frequent quarrel, blaming, and other manifestations of anger. Economic difficulties, increase in domestic work, and psychological effects experienced by mothers are also noted. The latter include anxiety, worry, being scared and loss of weight. Only a very few observed the effect on the unwanted child.
- Across the use-category, majority of women reported having received reproductive services connected with prenatal care, child health care and nutrition counseling.
- Data on services for reproductive tract infections suggest lack or inadequacy of such services hence very few were able to avail. Only a negligible number (less than three percent) have received Reproductive Tract Infection (RTI) and Sexually Transmitted Diseases (STD) exams and treatment.
- The three most popular services which women would like to receive are pelvic and breast examination and pap smear.
- Never users are at a disadvantage in comparison with the ever users with regard to utilization of reproductive health services.
- Family planning services are generally obtained from the public sector notably the Rural Health Unit (RHU).
- A large majority of women reported having no problem with the most recent family planning services. However, for those who encountered problems, the most mentioned are shortage of supplies, clinic/source is far from their homes and long waiting time.
- Family planning services considered as most important are user's friendly staff, clean clinics, and nearness to home.
- Women suggest that easy accessibility of family planning services, more information, longer clinic hours, and less expense would satisfy their needs.
- To perform breast exam, pelvic exam, pap smear, IUD insertion, and STD diagnosis, a female service provider is the preference of women. Majority of women in the study would refuse such services if given by a male service provider. Tolerance for male service provider is expressed in giving injection and family planning counseling.

Implications and Recommendations

The data indicate significant differences between never users and ever users in which the latter hold an economic and social advantage. This result does not however establish a causal link between family planning use and better socio-economic conditions. Basically, association in nature, the use or non-use of family planning is seen to yield differences in terms of economic and social attributes as well as variations in reproductive health needs.

At the outset, the data establish that majority of women covered in the study are current users. Nearly one-fourth had never used any contraception and the remaining are current non-users at the interview time.

The average duration of marriage and the age at first marriage indicate more or less a similar period of exposure to the risk of pregnancy across the three FP statuses, albeit the never users years in marital state is slightly lower (average of 11 years) than the ever users (13 years for current non-users and 12 years for current users).

Moreover, the never users have a slightly smaller household size and are slightly younger in age that the ever-users, yet they are disadvantaged economic-wise. With lower household income to manage and less years of schooling, the never users are more likely burdened in household management. Their capacity to earn, to augment household income may be drastically limited. They worked more hours in domestic activities compared with their users counterpart.

Taking fertility awareness and practices as a core element to the pursuit of reproductive health and focusing on the indicators of reproductive needs brought to fore the disadvantaged position of never users in terms of knowledge in family planning methods, in difficulty to bear children (infertility), access to reproductive health services notably RTI exams and treatment, pap smear, breast and pelvic examination.

Over-all, women are more knowledgeable about modern methods than about the traditional FP methods. Knowledge on natural family planning and LAM as modern contraceptions are inadequate as evidenced by the small percentage of women reporting to have known these methods.

The striking pattern, however, is the fact that whether or not a method is modern or the traditional, more ever users are knowledgeable than the never users.

The fact that knowledge of family planning is not spontaneous and women had to be prompted in method identification implies a likelihood of considerable gaps in knowledge. The mere affirmation of knowing a method does not guarantee that women, users and never users, are conversant and familiar on the workings of a method. Knowledge here may be skin-deep, acquired through ads promoting FP or through friends/relatives with scant information to share.

Knowledge on the dimension of reproductive health is high. An overwhelming majority affirmed that reproductive health includes the ability to bear children, to choose the number of children, physical and mental well-being, and the ability to have a satisfying sex life. However, there are some women of traditional mold who negate that satisfying sex life falls under reproductive health.

Infertility is a reproductive concern; thirty-one percent (31%) of never users professed difficult conception, twenty-five percent (25%) and eleven percent (11%) of current non-users and current users respectively have the same problem. Among the infertile women, the concern is greater for never users. The contraception problem is not largely because of infecund state (post menopausal, involuntary or voluntary infertility) as in the case of ever-users. Perhaps the difficulty in conceiving explains why never users did not resort to contraception.

Unwanted pregnancy bespeaks of reproductive health needs. Majority of ever-users experienced being pregnant at the time when they were not ready. Consistent with the infertility result, less number of never users have the same experience.

Occurrence of unwanted pregnancy, according to FGD participants, yielded stressful relations not only between couples but also with the children. The family in constant stress molds people's values and orientation, which are at variance with societal norms.

The problem of infertility and unwanted pregnancy seems to be exacerbated by the inadequacy of reproductive health services. The situation is open to programmatic concerns. For instance, under the devolved system of governance, can a local health unit be able to provide such services? Can midwives be trained to perform examinations and handle treatment of RTI?

Women considered users-friendly staff, clean clinics and nearness of service delivery points to their homes as important characteristics of family planning services. Moreover, female providers are preferred by women in the delivery of reproductive health services.

These are desired health services which are seemingly attainable. There is no doubt that urban health clinics and service providers can grapple with these desirables but the crux of the matter is whether or not these desirables can be delivered to rural and tribal communities or to areas where local government units are hard up and unable to provide for such services. The balancing act of providing health, economic, and infrastructure services may tax local units whose meager resources have to be stretched to the limit.

It is then imperative that women and men or couples for that matter must take the initiative and the commitment to work, plan, and manage their family.

This presupposes that couples can avail of adequate information to make informed choices on which family planning method to adopt, the availability of services and a support system within the community.

To diffuse the heavy workload of the local health centers, and to alleviate economic burden of local governance, the community members have to organize themselves and allocate functions and responsibilities to civic and religious groups.

For adequate information and education, NGOs and women's group may take on this task. In tandem with the religious groups, the IEC approach can well be directed to the grassroots level in consonance with various religious affiliations of the people. Counseling task can also be one of their activities.

The availability of services has to be upgraded, integrating quality of care and should be the responsibility of local health boards and local health centers. The local health board has to be tasked with monitoring and evaluating service delivery performance. Maintenance of clean service points should be given high priority.

A network of support systems has to be evolved in a community. These will be composed of dedicated core groups which can mobilize and put pressure on local government as well as planners and policy makers. This network may take the responsibility of linking with groups outside the community to generate assistance and support for women's concerns.

C. Correlates of Domestic Violence

Rationale

The International Bill of Human Rights defines domestic violence as all physical, psychological/emotional, sexual, and financial acts between and among family or household members in the form of abuse of one's power over another within the concept of inequality.

Domestic or family violence is a socio-cultural phenomenon that cuts across social classes. Being socially-defined, socially-patterned, and socially-caused, domestic violence covers a plethora of abuses done to women, children, the elderly and domestic helpers and occasionally, men. Moreover, the continuous exposure and re-enforcement of the abuses through observation and vicarious experiences render the act seemingly normal and natural.

The home is where the interplay of "heart and hurt" occurs and where the two faces of reality are starkly displayed. One face manifests unconditional love and bonding sustained through the years and seen through imprints of shared responsibilities and care, of devotion and loyalty. In many families, there are scars of crises withstood and sacrifices freely given that can still be discerned.

The other face is a picture of hostilities inflicted and sufferings endured. It tells of traumatic experiences and cruel acts; some are forgiven and understood, others remain in the subconscious, eroded perhaps over time by love-evoking instances and happy memories.

The two faces of home realities impinge upon family relationships. Clashes of opinion, different interests and disagreements are the milder forms of conflict situations; these, however, may pave the way to more violent, disruptive, and destructive consequences.

Conflict does exist in every home and beyond. In some instances, violence and physical force are modes of conflict resolution. The family as a microcosm of social relationships is a setting of power plays--the intent of controlling, disempowering, and sometimes injuring other members, on the basis mostly of age and gender. Violence in a domicile may have physical, verbal, economic, emotional, or sexual forms.

Physical violence is almost always preceded or accompanied by verbal abuse. Regular and repetitive name-calling for instance, can damage self-esteem. The regularity and constant occurrence of the act, though, may dull the senses and render ineffectual the sting of verbal abuse. Nevertheless, persistent verbal abuse even without physical brutalities can be devastating emotionally and psychologically. Its effect may be hidden in the subconscious, become dormant for a period of time, can germinate, develop and be released as violent behavior.

Economic abuse takes the form of withholding economic resources and benefits, or ignoring the economic needs of family members. While a Filipino wife is usually the holder of the purse string, this rarely gives her any power. It is more likely a burden as the wife has to stretch the very limited resources and to find means to augment the meager income.
Sexual violence does not always entail physical injury but victims invariably suffer emotional trauma. Basically, any sexual experience from touching, fondling, and fingering to oral, vaginal or anal intercourse falls under the rubric of sexual abuse if and when such experience occurs without consent and/or with accompanying use of force.

Domestic violence is a century-old problem that has been accepted, tolerated, and perpetuated by cultural norms. Such an attribution makes domestic violence a social reality taken as a way of life. However, in the past decade, a new consciousness has emerged; violence at home is viewed as a human right violation and a public health concern. This brings to fore, the moral, socio-cultural, political and personal ramifications of domestic abuse.

Empirical data on domestic violence are scant and difficult to find (ISSA, 1996). Whatever data are available are likely to underestimate the reported abuses in the family. Secrecy, insufficient evidence, and social and legal barriers continue to make accurate data on domestic abuse difficult to obtain (United Nations, 1991). For instance, the Safe Motherhood Survey in 1993 (covering a national sample of 15,000 women) reported that ten percent (10%) of sample women between the ages of 15 to 49 years experienced physical harm. Researchers assert that this figure is most likely underreported. On the other hand, records of Department of Social Welfare and Development (DSWD), police precincts, special cases reported to women, nongovernment organizations (NGOs), and results from surveys conducted from small-scale samples indicate a higher incidence of spouse abuse.

As mentioned earlier, domestic violence consists of abuses done to spouse, children, the elderly and domestic helpers. This paper focuses on spouse abuse, more specifically, wife abuse, since in about ninety percent (90%) of domestic violence cases, the victims are women.

The Objectives

Taken from a larger study with broad objectives of looking at the impact of family planning use on women's lives, this analysis confines its scope to domestic abuse with the following specific objectives:

a) To determine variations of domestic abuse in terms of community condition: If indeed domestic violence cuts across socio-economic classes, is there variation in the magnitude of domestic abuses between depressed, non-depressed and tribal communities and between urban and rural areas?
b) To identify household variables which are significantly correlated with domestic abuse: Premised on the fact that the family setting and condition existing in the household may either enhance harmonious relationships or may trigger violent acts, the identification of specific household factors will provide insights into domestic troubles.

c) Congruent with the identification of household variables, there are family relations and activities that denote the exercise of power and control. It may be the lack of power or the abundance of it that may explain one's tendency to inflict harm or violent acts to another. Specifically, the paper aims to relate power and control variables (which include land ownership, task allocation, and decision-making in the family) to domestic abuse.

d) To determine the association between personal traits and related situational inducements which an individual responds to, either negatively or positively: Personal attributes like age, education, number of pregnancies, age at first marriage, and religion may be associated with spouse abuse. In like manner, situation-inducing behavior such as family planning variables (length of family planning use, status of use) and unwanted pregnancies are deemed to be associated with domestic abuse.

The Conceptual Framework

The similarity of societal behavior across cultures is well-documented in voluminous social and anthropological studies. Empirical evidences attest to the universality of behavior patterns and traits, albeit diversities exist, making one culture unique and interesting. The similarities and diversities in behavior are borne out of the meaning and value attached to it. This core of behavioral pattern is regulated and perpetuated by social norms.

Societal norms are forms of social control; deviation from the established and accepted ways of doing things is punished. Those acts that violate societal expectation are frowned upon and are labeled as deviant acts (Hunt, et al., 1987) although such behavior is relative, subject to interpretation and differential social reactions (Shoemaker, 1990). Aside from variability in interpretation and reactions, deviant behavior may be categorized according to how a culture accepts, reinforces, and sustains such deviance. For instance, rape is usually a transgression of what is acceptable. However, there are cultures that accept such an act as customary in cultural ritual. This transgressive normative stamp also determines the acceptability and practice of violence in a household setting.

The transgressive normative and non-normative categorization finds explicit manifestation in sexual violence (Heise, et. al., 1995). Marital rape is a form of deviant act which falls under the transgressive normative category in which a husband goes beyond what is acceptable. But culture condones the act because a wife is perceived as a property of the husband. Rape-incest, though, is transgressive non-normative because the rapist commits an unacceptable act violative of societal norms. Society does not condone such an act under any circumstances.

Violence at home is hardly a new social phenomenon.[*] It is however a new issue as it occupies the center stage of consciousness and increasing concern for the victims of domestic abuse has emerged during the past decade.

[*] It is difficult to know whether domestic violence has increased over time but one could argue that urbanization, social disorganization, the rise of the nuclear family, and weakening of social ties among people may allow more domestic violence to occur. In traditional rural areas where everyone knows everyone else's business, domestic violence may be discouraged or tempered. When there is more privacy (urban areas, nuclear family, sealed-up and airconditioned houses), there may be more domestic violence. Men's loss of traditional roles and drinking are also plausible preconditions.

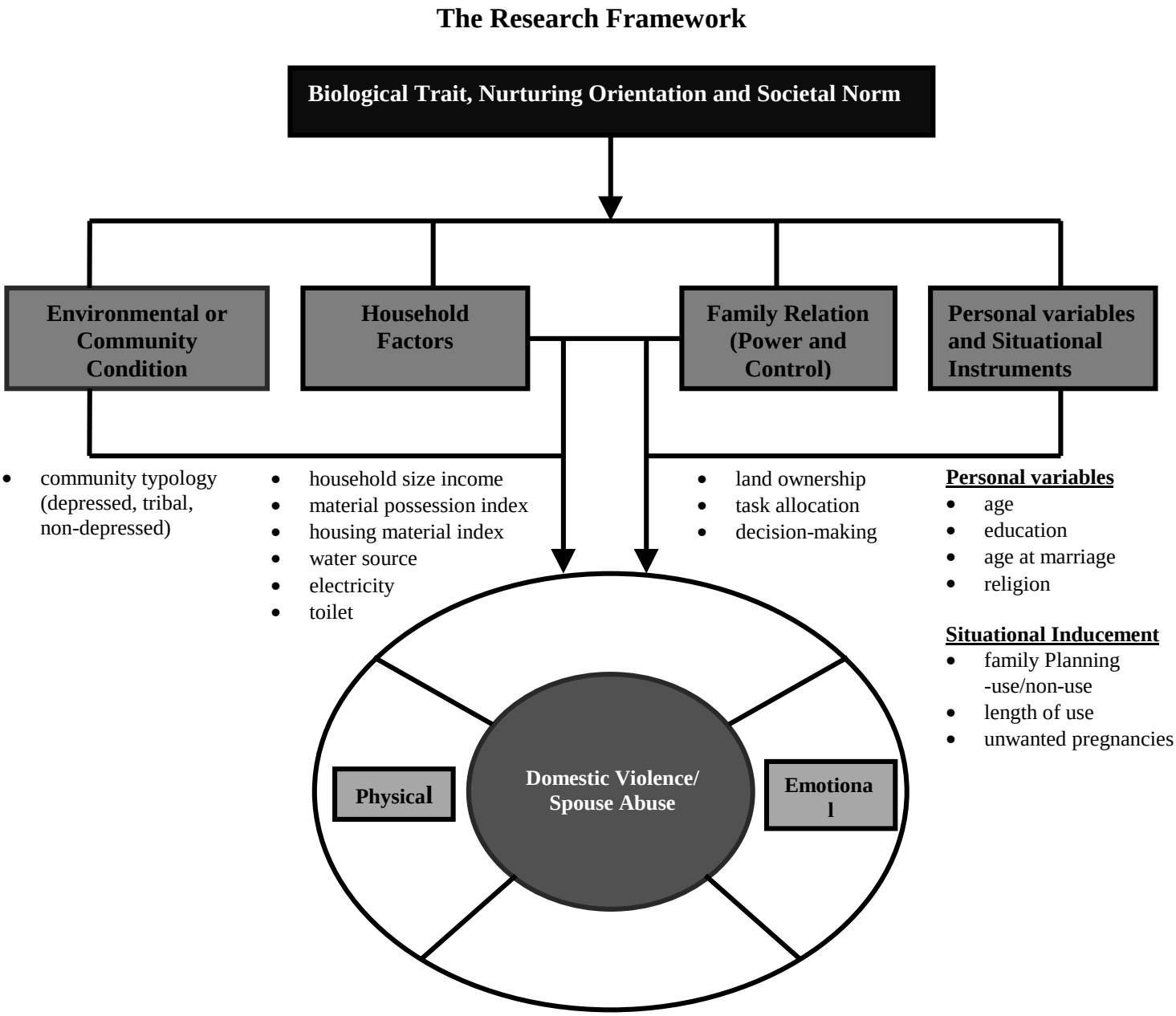
What explains abuse at home? What are the conditions, attributes and traits associated with violent acts? Why do people inflict harm on those whom they pledge "to love and cherish…till death do us part?"

The schema of relationships depicted in Figure C1 identifies and shows the association between variables. The whole paradigm is premised on the assumption that domestic violence is a response of the individual to a plethora of factors in the community, household/family, and some personal as well as situational inducements. These factors have been formed, nurtured, shaped, and sustained by genetic or biological proclivities, nurturance orientation, and prevailing societal norms.

The causal underpinning of biological and bio-social factors can be gleaned from the works of Finch (1938), Von Hemtig (1945), Glueck (1950), all cited in Shoemaker (1990) as factors that predispose one to criminality. Basically, their assumption posits that internal biological tendencies and conditions mutually interact with environmental forces affecting one's responses to events.

The link presupposes biological transmission from parent to child of some aberrant streak of genes which explains negative and violent behavior. Although most of these theories focus on criminality and delinquent behavior, their application to domestic violence is not off-tangent.

Figure 2. Schema of Relationship between Domestic Violence and Identified Correlates



The nurturance orientation takes from psychological theories of criminal behavior. Violent acts are said to be manifestations of underlying conflict within the individual framework brought about by the genesis of one's personality during childhood. Individual differences in intelligence and personality separate criminals and non-criminals; their on-going life experiences shape the development of their personality (Shoemaker, 1990).

Social and environmental explanations to behavior, more specifically delinquency and criminal behavior are plentiful (Durkheim, 1933; Show and Mackay, 1942; Merton, 1957; Morris, 1958; Clinard, 1964; Voss and Petersen, 1971). Among the many assumptions involved in this array of factors, one, which has relevance and appeal to the analysis of the link between domestic violence and social/environmental determinants, is the breakdown of institutional and community-based control. This breakdown of control could be due to the confluence of industrialization, urbanization, modernization, and migration processes.

The study by Morris (1958) maintains that crime causation is due to poverty, ignorance, and population density. Grafting from a similar vein, the schema includes household factors such as household size and poverty indicators (income, material possessions, housing materials and household amenities) as correlates of domestic violence.

Family factors as an explanation to violent behavior were made prominent in the late nineteenth and early twentieth century (Sanders, 1970; Krisberg and Austin 1978 as cited in Shoemaker, 1990). The overwhelming responsibilities and stress within marriage, the burden of nurturing children in addition to countless anxieties and uncertainties make family relations difficult and demanding. Moreover, family relations characterized by violence breed individuals whose relationships in later years could also be turbulent and prone to abusive reactions.

Interpersonal relations within the family and situational inducements may account for aberrant abusive behavior. In general, human behavior, including violent and criminal acts, is flexible and not fixed; it changes according to circumstances and situations (Shoemaker, 1990). Responses to a particular event are influenced by constraining circumstances or could be induced by existing situations. An earlier explanation of Sutherland (1939) emphasized that learning of delinquent behavior occurs in small informal groups and develops from collective experiences as well as from specific situational events.

The Empirical Results

Patterns of Domestic Violence (Table C1). As mentioned in earlier sections, domestic abuse can be physical, emotional, sexual, and economic. Indicators of violence in this study deal more with physical and emotional abuse.

Over-all, one of every four women reports that she has been physically hurt. A higher percentage is observed among the urban sample. Nearly one-fifth among those who experienced physical violence reported frequent abuse while greater majorities say it is seldom done. It is more likely that these figures are underreported, because inspite of increasing awareness, most women, especially from rural areas, are hesitant to report abuses done to them.

Over one-third of women from all areas profess that physical abuse occurs when their spouses are drunk. A greater percentage (45%) of women from depressed places experienced being battered when the husband is in stupor due to alcohol. Physical violence also occurs during quarrels or disagreements. Other instances cited can be classified as mitigating circumstances and possible causes which include jealousy of husband, gambling habits, having an affair and being engrossed with "*barkada* (activities of peer)." One out of every 5 respondents attributed the experienced violence to above-mentioned circumstances.

Physical violence can take place in single or multiple acts. Single acts (e.g. a slap or a kick) were often justified as an impulsive negative response to situation-inducing anger or rage. Over two-thirds of women across areas experienced single acts of violence but one-third reported suffering a series of multiple abusive acts.

The three most mentioned single physical violent acts include punching, slapping, or kicking. The majority of women experience either being punched or slapped.

The interesting picture is presented by women from urbanized places of Bukidnon. They reported the least percentage of physical abuse experience, yet they also have greater incidence of frequent abuses. Quite a number (31) of women from non-depressed areas of Bukidnon reported being physically harmed when they got pregnant.

The most common type of abusive behavior falling under the rubric of emotional violence is name-calling, a derogatory labeling which is damaging to one's self-esteem. Two out of every five women affirmed being frequently abused in this manner. Yelling ranked next followed by fault-finding.

Name-calling is considered by some women to be more hurtful than physical abuse. As one participant in the FGD said, "to be called *tanga* (stupid) and *buang* (crazy) is more painful than being hit."

Ironically enough, women participants in Focus Group Discussions were unanimous in declaring that it is usually the wife who initiates the abusive act. Nagging when the husband is drunk or when the husband comes home late was the common reported act that preceded the abuses.

Urban husbands gave a different version as to what triggered domestic violence. After the day's work and they are at home, the wives would urge them to do the household chores. Tired after the heavy workload, they snapped and argument ensued. As heated verbal exchange intensified, violent acts were likely to occur.

Payday is the reported time when domestic abuses happened. One participant jokingly said, "payday has to be abolished." The take home pay is not only inadequate; it is too little to cover basic minimum food requirements. The condition renders volatile temperament; frustration with the inadequacy of resources leads to domestic fights.

An over-all index of abuse was constructed by adding up items which constitute physical and emotional abusive acts. Three groupings were subsequently formed, namely none (0 score); low (1.0 to 3.9); and high (4.0 and over).

A little over one-third of women reported not ever having experienced any abuse. It seems that the Bukidnon women are at an advantage over their urban counterpart.

Responses to violence are generally passive-reactive in nature. Both urban and rural women participants in the Focus Group Discussions confided that their usual reaction is just to cry or to keep mum. They cry because of the hurt, the pain, and the frustration. They kept silent to diffuse the husband's anger and not to make things worst. Other FGD participants revealed the technique of "dawn talk" when husbands were at their sober moments and were inclined to listen. As expected, husbands generally experienced regrets, "*I'm sorry, I promise this will never happen again*."

Some women voiced their concern that if they retaliate and fight, their husbands may leave them and their children. Several women whose family and relatives are in the vicinity reported fighting back when the husband tried to maltreat them. Women agreed that indeed if there is a support system (presence of relatives and friends), abusers tend to curb their propensity for harm. A woman participant from a tribal community related how she stopped her husband from violent acts. She screamed and shouted until the entire neighborhood congregated in the front of their house. The husband was so ashamed, he left to cool off.

A number of participants reported how their children react to violent episode. A husband from an urban area reported how violent he could be. He breaks whatever objects he can lay his hand on, and the breaking sounds terrify the children. He would try to ease his children's fear but to no avail. His children are ill-at-ease with him. Other participants attested that children would run to nearby households; some would cry and hug their mother; others would urge the mother to leave home. In some instances, husbands utilized the children as medium for couples' reconciliation.

Table C1. Percent Distribution of Women 15 - 49 by Domestic Violence Related Variables by Community Type: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

	Urban	Rural			Both Rural & Urban
		Non-depressed	Depressed	Tribal	
Percent Affirming/Reporting					
• Ever physically abused by spouse	28.0 (n=1,00)	18.1 (n=270)	25.6 (n=270)	20.8 (n=120)	25.5 (n=1,660)
• Frequency of abuse (n=423)					
- often	17.4	28.6	3.2	16.0	19.4
- seldom	82.6	69.4	76.8	84.0	79.2
- no response	----	----	----	----	1.4
• Instances in which abuse/ violence occur:					
during quarrel/disagreement	17.7	14.0	28.3	23.8	19.3
when drunk	32.7	41.9	45.0	38.1	35.9
when spouse got pregnant	5.4	11.6	6.7	0.0	6.0
financial and economic related difficulties	6.5	4.6	1.7	9.5	5.7
(Husband-related reasons) jealousy, gambling, having affairs with women, barkada	21.5	16.3	15.0	14.3	13.5
(Wife-related reasons) refusal to have sex, wife neglect, bad mood, going out without husband's knowledge, neglect of children, and personal adjustment period	16.2	11.6	3.3	14.3	13.5
Total	100.0	100.0	100.0	100.0	100.0
• Experiences of specific physical violence					
- single violent act	68.6	71.4	60.9	68.0	67.4
- multiple violent acts	31.4	28.6	39.1	32.0	32.6
• Most common single abusive act (for those who experienced physical abuse)					
- punching	53.2	69.4	65.2	52.0	57.0
- slapping	56.4	53.1	69.4	28.0	52.7
- kicking	35.0	38.8	33.3	24.0	34.5

Relationship of Domestic Violence with Identified Correlates. Two measures of association are utilized: the Pearson r for interval data and the chi-square statistics for nominal variables. Table C2 identifies which of the variables is correlated with domestic violence.

The urban area tends to be associated with a high incidence of abuses. This lends support to the social and environmental explanation of violent behavior (Durkheim, 1933; Show and Mackay, 1942; Merton, 1957; Morris, 1958; Clinard, 1964; Voss and Petersen, 1971).

Among the personal attributes of women, age at marriage and religion are strong correlates of spouse abuse. Women who were married young, at age nineteen years or below, are prone to experience a higher incidence of abuse. Although four out of every five women are Catholic, data show that non-Catholic women are recipients of fewer violent episodes.

Situations that induce violent behavior in marriage relations include family planning use, length of use, and experiences of unwanted pregnancy. Ever-users seem to be more at the receiving end of domestic abuse compared with the never-users. It is debatable, but not improbable that the liberating effect of family planning use on women ushers a consciousness, an incipient feel of power to be their own person thus they are less subservient. This may pave the way to a struggle for self-assertion, and in the process, abusive behavior is the response of husbands to cope with the change.

The total number of months of family planning use is also shown to be correlated with the index of domestic abuse. Higher occurrence of violent behavior seems to be associated with long years of practicing family planning. Forty-three percent of those women with a high index of violence have been using a family planning method for three years and over.

The experience of unwanted pregnancy is also related to the incidence of spouse abuse. Fifty-seven percent who are categorized as having a high index of domestic violence have experienced unwanted pregnancy.

Among the indicators of household socio-economic status are income, index of material possessions, toilet facilities, and source of drinking water which are found to be significantly related to domestic violence. Thirty-five percent of women with a high index of violence have incomes of less than 2,500 pesos. The same pattern is observed regarding the material possession index. Among women with high incidence of violence, the percentage of those with a large number of material possessions is two times less than those with low material acquisition (1-5 items). Women who spend more hours in doing household chores are less likely to be inflicted by harm and abuse. Could it be that a spouse finds no cause to engage in violent outbursts because everything that needs to be taken care of is in order? Or could it be that wives become too tired to nag, argue, and find fault after long hours of doing household work?

In terms of better housing amenities like piped water and better toilet facilities, the greater occurrence of abuse is more likely to happen in households with poorer amenities.

Table C2. Measure of Association Between Correlates of Abuse and Index of Domestic Violence: Women's Studies Project. Cagayan de Oro and Bukidnon Province, 1996.

Correlates of Abuse	Mean/Percent	Measure of Association r	Measure of Association x^2	Level of Significance
1. Area (Percent from urban/city)	59.8	__	66.751	.001
2. Personal Correlates				
- age of wife	32.4	.0080	4.959	n.s.
- education of wife	9.6	.0430*	6.858	n.s.
- age at first marriage	20.6	.1008**	12.717	.001
- religion (Percent Catholic)	82.5	---	21.117	.001
3. Situational Inducement Variables				
- ever-used family planning (percent ever-used)	75.7	----	9.307	.01
- length of use (average in months)	43.8	.0338*	13.961	.05
- unwanted pregnancies (percent)	46.1	---	26.713	.001
4. Household Variables				
- total cash income	P5,018.60	_.0051	17.620	.05
- housing material (percent with strong material)	73.5	.0083	1.723	n.s.
- material possession index	4.4	_.1008**	21.121	.001
- total hours for household chores	6.2	_.0223	9.428	.05
- household size	5.9	.0287	2.767	n.s.
- toilet (percent with good toilets)	63.4	----	5.643	.05
- source of water (percent with piped water)	74.5	----	16.554	.01

Specific tasks in the household are associated with the index of domestic violence (Table C3). Relating the doer of the task with the index of domestic violence resulted in the identification of household activities that are correlated with abuse. For instance:

- wife who earns a living is likely to be a recipient of violent acts;
- husband who does the cooking is more likely to inflict harm;
- husband who performs the tasks of cleaning and washing tends to be abusive;
- wife who does the marketing is less likely to be abused;
- husband who controls the household budget has the tendency to inflict harm on the wife;
- husband who takes care of the children tends to be abusive; and
- high incidence of abuse is likely to occur if the husband is tasked with caring for sick children.

The above association between domestic violence index and household tasks simply implies one dominant pattern, namely, that when husbands are saddled with household tasks the incidence of violent acts is more likely to increase. The abusive tendency may be triggered by doing such

tasks, which husbands may consider degrading to a man. Household work definitely taints the macho image, aside from the fact that the work exhausts the patience and endurance.

Table C3. Measures of Association Between Specific Task and Domestic Violence: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

	X^2	Level of Significance
Earn a living	18.678	.001
Cooking	10.639	.05
Cleaning and washing	23.475	.001
Marketing	17.484	.001
Control of household budget	20.218	.001
Cleaning the house	8.557	n.s.
Laundry	7.391	n.s.
Taking care of children	15.295	.01
Care-giver of sick children	12.957	.01
Repair in the house	5.625	n.s.
Raising livestock	3.917	n.s.
Gardening	5.285	n.s.
Attending local/barangay activities	9.404	n.s.

Specific decision-making acts related to the index of domestic violence reveal interesting results (Table C4). Decision-making related to children is not associated with incidence of domestic abuse except decisions involving children's discipline. Husbands who exercise this authority are less likely to inflict harm on the wife. This pattern conforms with the explanation about power and control. The husband will inflict harm when his power over his children is threatened by the wife.

When a wife exercises authority by making major decisions in selling or buying important family possessions (e.g. land), she is likely to experience abuse. If a husband is saddled with decisions on what to buy in the market and what to cook, he tends to be abusive. However, on buying expensive things (e.g. appliances), he will resent it if the wife will not give him the power to decide. If a wife insists on making the decision, she will most likely be harmed.

Another decision-making problem related to domestic abuse is giving assistance to parents, in-laws, or relatives. Assistance could be financial or in kind. To give or withhold assistance seems to be the husband's decision; to overrule that authority translates to a transgression and the wife is more likely to suffer abuse.

A woman's unilateral decision to work outside the house is not an allowable option. The husband makes the decision whether or not the wife can work. Abusive acts are likely to be inflicted on the wife if she decides on this matter.

The husband is less likely to inflict harm if he is given the authority to decide on the wife's predisposition to socialize or to visit friends and relatives. This is not surprising. In instances

when a wife overstays her visit, she is more likely to neglect household chores, creating an inducing-situation for domestic quarrels that may lead to abusive acts.

In summary, domestic abuse is associated with urban residence, with fewer household variables (income, material possession, hours spent for household chores, toilet facilities, and source of water supply), with personal attributes like younger age at marriage, religion, and situational inducement variables (family planning use, length of use, and unwanted pregnancies).

Moreover, domestic violence is related to responsibility in household tasks primarily reflecting productive and reproductive roles. A shift of responsibility to husbands on tasks like cooking, cleaning, marketing, handling of household budget, and care-giving, all defined as women's tasks, may result in acts of abuse. These tasks may perhaps be viewed by men as demeaning to their image as the head of the family; they may feel castrated of their manhood by performing household tasks; such resentment sometimes finds an outlet for inflicting harm on the partner.

In the area of decision-making, domestic abuse is associated with decisions on child discipline and on economic-related problems like what to buy and cook, buying appliances and expensive items, selling and buying family possessions, deciding whether the wife will work or not, and giving assistance to parents or in-laws.

Among the social, cultural, and family relation variables, the wife's making decisions on visiting friends and relatives is associated with acts of violence.

Table C4. Measure of Association Between Specific Decision-Making Item, and Index of Domestic Violence Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

	X^2	Level of Significance
A. Decisions related to Children		
- number of children to have	6.801	n.s.
- family planning method to use	2.898	n.s.
- discipline children	23.823	n.s.
- what to do when a child is sick	3.657	n.s.
- course to take	7.229	n.s.
- choosing child's spouse	2.222	n.s
- school to study	6.157	n.s.
B. Economic Decision-Making		
- what to buy and cook	25.808	.001
- buying appliances and expensive items	23.722	.001
- buying personal items/grooming	5.395	n.s.
- selling/buying family possession	12.994	.01
- hire servants	7.047	n.s.
- working outside house	49.044	.001
- giving assistance/support to in-laws	17.564	.01
C. Social, Cultural and Family Relations		
- initiates reconciliation after a quarrel	5.387	n.s.
- whose religion to prevail	3.298	n.s.
- visit relatives and friends	11.636	.05

These identified correlates related to domestic violence were further subjected to multi-variate analysis. The significant relationships found in relating two variables at a time were not sustained in a multivariate analysis (Table C5).

The rural/urban residence and domestic violence connection persists; urban women tend to experience more incidence of domestic abuse than their rural counterparts. Material possession as proxy indicators of poverty is shown to have an inverse relation with domestic violence; women with fewer household possessions have higher index of abuse.

Among the household tasks, which have significant relationships with domestic abuse, only marketing, washing and cleaning remain to be strong correlates. On decision-making problems, decisions on working outside the house and discipline of children maintain their significant relationship with domestic abuse. The autonomy of the wife to work outside the house is imperiled by violence if the decision-maker is herself. The same is true with regard to children's discipline.

The relationships between all personal and situational inducement variables and domestic violence were found to be not significant under multivariate statistical treatment.

Table C5. Multiple Regression of Domestic Violence Index and Its Correlates: Women Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Variables	b	T-Value	P-level
Area	2.8234	2.727	.01
Household Size	_0.0586	_.552	n.s.
Income	_0.0009	_1.596	n.s.
Index of material possession	_.1367	_2.067	.05
Index of housing material	.1528	.932	n.s.
Land ownership	_.0036	_.885	n.s.
Marketing task	_1.6090	_3.098	.01
Cleaning/washing task	_.27260	_2.248	.05
Working outside house	1.3067	3.101	.01
Decision-making problems on child discipline	.9524	3.043	.01
Age of women	.0513	1.384	n.s.
Education of women	.0880	1.581	n.s.
Age at first marriage	_.0272	_.521	n.s.
Religion	.3664	1.028	n.s.
Ever-user status	_.5135	_1.195	n.s.
Unwanted pregnancies	.1425	.465	n.s
$r = .7587$			
$r^2 = .5756$			
s.e. = 1.421			

Conclusion and Recommendations

This paper aims to determine variations of domestic abuse by community type, to identify household variables that are correlated with abuses at home and to relate power and control variables as well as women's personal traits to domestic violence. The highlights of the empirical investigation are as follows:

Patterns of Domestic Abuse

- One in every four women in both areas (Bukidnon and Cagayan de Oro) reported being ever physically harmed.
- Among those who experienced physical abuse, nineteen percent (19%) affirmed the frequent repetition of the act.
- Physical abuse is more likely to happen when the husband is drunk, during a quarrel or disagreement.
- Reasons cited are attributed to the husband which includes jealousy, gambling, having an affair with another woman, and being engrossed in *barkada* activities.

- Reasons attributed to the wife include refusal to have sex, negligence in caring for the children, going out without the husband's knowledge and difficulty in adjusting to husband's ways.
- Two-thirds of physical violence consist of single acts of abuse. The most common acts are punching, slapping and kicking.
- Severe (high index) physical and emotional abuse happens to 21 percent of women; more than one-third report no experience of violence.

Correlates of Abuses

- Among the hypothesized correlates of domestic abuse, the following are significantly related to domestic abuse.

    - Women from urban areas tend to experience more incidence of domestic violence than their rural counterparts.
    - Husbands performing household tasks, specifically the cleaning and washing in the household, have a greater proclivity towards domestic violence.
    - Wives who make decisions on the manner of disciplining children tend to be recipients of domestic abuse.
    - Husbands who perform marketing tasks are prone to be abusive.
    - Wives who decide to work outside the house tend to be abused.
    - Domestic abuse seems to occur more in households with low material possessions.

Implications

The greater incidence of domestic abuse reported in urban households can be due to urban-related stress or to the fact that urban women have a higher level of consciousness with regard to their rights. Moreover, it can be further surmised that urbanites have attained a certain degree of openness, hence reporting abuses done to them by their spouses is not something to be ashamed of. Silence on this occurrence may have been broken by women's effort to treat domestic violence as a public health issue.

That rural women report lower incidence of violence may be due to the fact that they are ashamed to reveal such brutalities or because emotional violent acts, notably name-calling are not considered as something transgressive or violative of their rights. It is not surprising if rural women will consider some forms of abuse as the normal way of behavior in the context of marriage.

The findings on correlates of domestic abuse give one important implication: if role reversal occurs in a household, that is, when the husband performs the household reproductive role, he tends to be abusive.

Poverty seems not to be directly related to domestic violence. However other indicators of socio-economic status are associated with domestic abuse.

Recommendations

The data suggest a need for more efforts on dissemination, advocacy and networking. There should be dissemination of information regarding domestic violence and educating both spouses not merely on avoidance of abuses but on more effective handling of conflict at the homefront.

Information dissemination and education should be directed in favor of rural couples who consider emotional abuse as a way of life and rationalize this as "natural behavior" for men. Other women blamed the wife (victim) who was perceived to be the initiator as she nagged an inebriated husband. The nagging is also construed as a manifestation of wife's unfounded jealousy.

Education by peers may work well. In a neighborhood cluster, a local-version of a soiree where couples could talk about topics affecting livelihood, health and children, and politics may prove an effective vehicle in educating and updating each other. Women can be initiators of the discussion and raise concerns about domestic violence in their dialogue.

Information dissemination can be made through radio albeit there are pockets of households (e.g. cultural communities) which do not have this communication medium. Educating both spouses on gender relations is essential. This can emphasize women's burden and disadvantaged position as well as give concern to the husband's predicament because an abusive person may be reaching out and needing help too.

The study found out that husbands doing household tasks tend to be abusive. This phenomenon can be explained by the fact that these tasks are tedious, perceived to lower the male's self-esteem and repetitive without visible output. Sharing of these tasks and definite assignment of things to be done may well be a learning process for couples and children as well.

The family, being the primary unit in society and the venue of the interplay of "love-hate" in relationships should be the main target of education and advocacy. Sharing of both productive and reproductive roles in the household setting eases the women's burden and allows husbands to perform nurturing tasks which may eventuate to a closer bonding not only by the couple but also between father and children.

Women's groups and NGOs have to strengthen their advocacy and networking. To effect change, there should be sustained advocacy and linkages on the individual, family and institutional levels. NGOs are crucial because authorities in institutions like the church, government, and the market are basically in the hands of men. The power that they hold especially in decision-making should be shared, doing away with the perception that men can do the job much better than women.

D. Women's Work and Family Size: The Case of Southern Philippines

Rationale

One of the potential benefits of family planning is the perceived greater ability of women to engage in productive activities with a smaller family size. Despite these presumed benefits, however, Podhisita et. al. (1990) contends that little is known about the impact of reduced family size on women's participation in the labor force. Thus, following the path taken by Podhisita et al. (1990), this study extends the research on women's work by examining the relationship between family size and domestic work among women in the Southern Philippines.

The relationship between family size and women's domestic work is complex because differences in levels of domestic work among women are determined not only by number of children but also by such factors as the income of the husband, the ages and sexes of the children, availability of jobs, availability of child-care help such as servants, the educational attainment of the woman, availability of financial and child care support from relatives, the available resources of the family such as ownership of farm land, and social and cultural norms. Moreover, domestic work is not easy to quantify and is not recognized in most GNP computations as having economic value. In many of these GNP estimates, women who are full-time housewives are classified as being part of the non-productive segment of the population. Women's rights advocates have been relentless in pointing out that this practice clearly discriminates against women. They argue that it is plain nonsense to claim that the work of women at home does not have economic value when in fact domestic work contributes greatly towards providing the basic needs of families, thus ensuring that family members remain useful and productive elements of society. Moreover, women's rights advocates argue that a woman's decision to work at home is in most cases prompted by a rational motive to maintain the economic viability of the family. Thus, one of the partners in a marriage must take care of domestic chores to permit the other to engage in economic activities outside the home. Women usually end up doing domestic work because of cultural reasons and considerations of "efficiency", that is, that women are more efficient at doing things at home than men (see Vanek 1980).

Very few studies in the Philippines have examined the relationship between family size and women's domestic work. However, several studies have come up with findings that indicate that a bigger family size increases the number of hours that women in developing countries spend for domestic work. For instance, the results of DaVanzo and Lee (1983), Everson et. al. (1979) and Domingo et. al. (1994) indicates that women in Malaysia and the Philippines spend a large portion of their time on childcare and home production. Moreover, the findings of Popkin (1980) and Everson et. al. (1979) indicates that even if women are involved in market work, they still spend a considerable amount of time on domestic work relative to men. Consequently, this study hopes to further clarify these issues by examining not only whether a larger family size brings about a heavier work burden for women at home but also if a larger family size brings about a "double burden" for women, that is, that women are not only burdened with more work at home but that they are also burdened with the need to do more market or paid work to support a bigger family.

The study uses data that are taken from urban barangays in the city of Cagayan de Oro and rural barangays in the province of Bukidnon. These two places, which are both located in the northern part of the island of Mindanao, provide the study with a timely opportunity to study the impact of family size on women's domestic work because these two places have recently experienced substantial economic growth and development. Such progress is a result of the present government's efforts to develop the vast natural resources of Mindanao and opening Mindanao areas to local and foreign investors. Moreover, the choice of urban and rural settings will give the study the chance to examine the impact of varying economic settings on the relationship between family size and women's domestic work.

The Model and Mean of the Variables

A model was developed in the study to examine the relationship between family size and women's domestic work. In this model, the number of hours that women spend on domestic work is presented as a function of the availability of child care help, number and ages of children, number of adults in the family, and a set of control variables representing economic, demographic and productivity variables. The inclusion of these variables in the model was based on the earlier discussion about on the theoretical relationship between family size and women's domestic work, from the results of the Focus Group Discussions (FGDs) and from the modeling work of studies that have examined the employment patterns of female workers (e.g. Long, 1980; Smith, 1980; Brown et. al., 1980; Polachek, 1981).[1]

This is a linear regression model with the number of hours in a day that a woman works at home as the dependent variable and the following as explanatory variables: woman's age, number of children under five, number of household members whose ages are 5 and over, years of schooling completed, the square of the years of completed schooling, whether woman's family has a servant or not, whether living in an urban area or not, whether living in a depressed area or not, whether living in a tribal area or not, income of husband, income of household from sources other than husband and wife's incomes, whether woman has used contraception or not, whether woman is engaged solely in domestic work (used as reference category for type of work variables), whether woman works in the informal or traditional sector, and whether woman is employed in the formal sector.[2]

Information on the number of hours spent for domestic work in a day was obtained in two ways. First, the women were asked the total number of hours that they usually spend for work at home in a day. Second, the women were asked to list all the household chores and tasks which they did in a day as well as the number of hours that they usually spend for each of them. Consequently, when the time that was spent for each activity in the second method was added and averaged for all the respondents, the figure that was obtained for the average number of hours that the respondents spent for domestic work in a day differed only by 8 minutes from the average that was obtained in the first method.

[1]Long (1980) used an 'hours of work' model that is almost identical to the model that is used in this study.

[2]The categorization of the women in the sample into three different work categories namely, domestic, informal and formal, is based on the International Labour Organization (ILO) classification of these work categories (see Meier 1989, pp. 147-151).

The inclusion of a “contraception” variable in the model is based on the assumption that a woman's non-use of contraception may be used as a proxy variable to capture the effects of cultural factors that dictate that a woman's place in marriage is the home. Viewed alternatively, this assumption presumes that a woman who has used contraception has freed herself of the need to conform to society's dictates that women stay at home and can choose for herself the career that she wants to pursue, even if such a choice necessitates that she spend most of her time away from home. Consequently, if there is truth to this hypothesis, then the foregoing model, holding the effects of other variables constant, should produce results that indicate that a woman who has not used contraception has a greater likelihood of being solely engaged in domestic work or working more hours at home compared to a woman who has used contraception.

Empirical Results

The mean of the variables and the mean hours spent for various activities undertaken by the women in the sample are given in Tables D1 to D6. Table D1 gives the mean characteristics of the females in the sample. Table D2 shows the mean hours worked at home by area stratum (whether urban or rural) of the women in the sample. Table D3 shows the mean hours spent by the women on various activities by area stratum. Table D4 shows the mean hours spent by the women on various activities by type of work category (whether domestic, formal or informal).

The figures in Table D1 indicate that both urban and rural women spend a considerable amount of their time working at home. Rural women spend an average of 6.5 hours in a day working at home while urban women spend an average of 6.0 hours in a day working at home. The slight difference in these figures is expected because the table also indicates that a higher percentage of the urban women are engaged in income-generating activities compared to rural women, which will undoubtedly act to reduce the time availability of urban women to stay and work at home.

The figures in Table D1 also indicate that, on the average, urban women have more years of schooling, have husbands who earn more, and have a greater likelihood of having used contraception compared to rural women. On the other hand, rural women, on the average, have more children compared to urban women.

Table D1. Mean Characteristics of the Females in the Sample: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Variables	Mean		
	Urban	Rural	Rural & Urban
Hours worked per day at home	6.0	6.5	6.2
Number of children under five	1.0	1.2	1.1
Members of the household aged 5 and over	4.6	4.7	4.6
Years of schooling completed	10.8	8.0	9.7
Percent living in urban	100.0	0.0	60.2
Percent living in rural	0.0	100.0	39.8
Percent living in depressed area	0.0	40.9	16.3
Percent living in non-depressed area	100.0	40.9	76.5
Percent living in tribal area	0.0	18.2	7.2
Age	32.5	32.4	32.4
Percent engaged in domestic work	72.4	80.3	75.5
Percent working in informal sector	23.1	17.1	20.7
Percent working in formal sector	4.5	2.6	3.7
Percent with household help	8.5	6.1	7.6
Percent who have used contraceptives	77.9	72.4	75.7
Total monthly income of husband	4,328	2,734	3,692
Size of sample	**1,000**	**660**	**1,660**

Moreover, it appears that domestic work constitutes a significant portion of the daily schedule of women who are engaged in income-generating activities. For instance, Table D2 shows that women who are engaged in informal sector work and formal sector work also spend, on the average, about 5.1 hours and 2.9 hours, respectively, on domestic work

On the whole, the descriptive statistics in Tables D1 and D2 appear to support the results of earlier studies that even if women are involved in market work, they still spend a considerable amount of time on domestic work.

Table D2. Mean Hours Worked at Home by Area Stratum for the Three Work Categories: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Work Categories	Hours Worked at Home in a Day			
	Urban	Rural	Rural & Urban	Sample Size
Women in Domestic Work only	6.6	6.7	6.7	1,254
Women in Informal Work	4.7	5.8	5.1	344
Women in Formal Work	2.6	3.7	2.9	62
Size of sample	**1,000**	**660**	**1,660**	

The figures in Tables D3 and D4 strongly support the findings of earlier studies (e.g. Domingo et. al., 1994) that women in developing countries spend a considerable portion of their time on childcare and home production. For instance, the summary in Table D3 indicate that the women in the sample spend a huge chunk of their time on the following childcare and home production activities: taking care and feeding of children; cooking and preparing of meals and snacks; washing and ironing of clothes; and cleaning of the house. Among these four activities, the number one activity in terms of time consumption is the taking care and feeding of children.

Table D3. Mean Hours Spent for Different Activities by Area Stratum (in a day): Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Variables	Mean		
	Urban	**Rural**	**Rural & Urban**
Cooking/preparing	1.43	1.71	1.54
Washing	0.15	0.28	0.20
Washing/ironing clothes	1.29	1.22	1.26
Cleaning the house	0.90	0.89	0.90
Preparing things needed by children/husband	0.04	0.06	0.05
Gardening	0.04	0.19	0.13
Taking care and feeding of children	0.09	1.68	1.79
Cleaning the backyard	1.86	0.16	0.09
Feeding animals	0.04	0.20	0.10
Marketing	0.04	0.00	0.07
Fetching water/gathering firewood	0.11	0.04	0.03
Caring for the elderly	0.02	0.00	0.00
Bringing children to school	0.04	0.01	0.03
Tending store/"carenderia"	0.57	0.28	0.46
Working in the office	0.32	0.15	0.26
Working in the farm	0.00	0.31	0.12
Handicrafts and related activities	0.15	0.01	0.09
Other income-generating activities	0.49	0.13	0.35
Total housekeeping and related activities	6.01	6.46	6.19
Total income-generating activities	1.54	0.89	1.28
Total housekeeping and income-generating activities	7.55	7.34	7.47
Size of sample	**1,000**	**660**	**1,660**

Table D4. Mean Hours Spent for Different Activities by Work Categories (in a day): Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Activities	Mean		
	Domestic	**Informal**	**Formal**
Cooking/preparing snacks	1.61	1.43	0.83
Washing dishes	0.22	0.16	0.03
Washing/ironing clothes	1.36	1.04	0.52
Cleaning the house	0.95	0.80	0.48
Preparing things needed by children/husband	0.06	0.01	0.07
Gardening	0.14	0.11	0.07
Taking care and feeding of children	2.03	1.12	0.80
Cleaning the backyard	0.09	0.11	0.01
Feeding animals	0.12	0.06	0.00
Marketing	0.04	0.14	0.10
Fetching water/gathering firewood	0.03	0.04	0.00
Caring for the elderly	0.00	0.00	0.00
Bringing children to school	0.03	0.03	0.01
Tending store/"carinderia"	0.00	2.19	0.13
Working in the office	0.00	0.00	6.86
Working in the farm	0.00	0.60	0.00
Handicrafts and related activities	0.00	0.46	0.00
Other income-generating activities	0.00	1.65	0.15
Total housekeeping and related activities	6.66	5.06	2.93
Total income-generating activities	0.00	4.89	7.14
Total housekeeping and income-generating activities	6.66	9.95	10.07
Size of sample	**1,254**	**344**	**62**

Tables D5 and D6 indicate that the wife controls the household budget. The tables also indicate that domestic chores such as cooking, cleaning, washing, marketing tasks, and taking care of children are largely the wife's responsibility while earning a living and house repairs are mainly the husband's responsibility. These figures are clearly consistent with the results of previous studies which have established that in most Filipino households, housework is the wife's responsibility while paid work is the husband's responsibility.

Table D5. Task Allocation in the Household: Women's Studies Project. Cagayan de Oro City and Bukidnon Province 1996.

Household Task	Responsible for Task			
	Wife	Husband	Both	Others
Earning a living	0.8	79.5	19.7	0.1
Cooking	83.7	1.8	9.9	4.6
Cleaning and washing after cooking and eating	79.2	0.8	5.7	14.2
Marketing tasks	75.3	9.4	12.5	2.8
Control of household budget	89.2	5.7	4.7	0.3
Cleaning the house	82.4	0.6	4.2	12.7
Washing and ironing of clothes	82.7	0.7	6.6	10.1
Taking care of children	85.0	0.6	11.6	2.7
Taking care of sick children	59.9	1.7	38.0	0.4
Taking care of the elderly	63.2	5.3	27.8	3.8
Accompanying children to school	69.4	11.9	8.3	10.4
Repairs in the house	3.7	85.3	2.2	8.7
Raising/feeding of backyard animals	36.7	28.6	29.4	5.3
Gardening	41.3	33.7	21.6	3.4
Attending barangay activities/affairs	47.2	34.7	16.3	1.8

Table D6. Task Allocation in the Household: Mean Values of the Task Allocation Index by Stratum (Urban/Rural): Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996

Household Task	Mean		
	Urban	Rural	Urban & Rural
Earning a living	-.770	-.800	-.782
Cooking	.773	.877	.814
Cleaning and washing after cooking and eating	.774	.838	.781
Marketing tasks	.575	.780	.657
Control of household budget	.795	.889	.832
Cleaning the house	.776	.871	.814
Washing and ironing of clothes	.778	.870	.814
Taking care of children	.783	.856	.812
Taking care of sick children	.601	.508	.564
Taking care of the elderly	.143	.083	.119
Accompanying children to school	.272	.192	.240
Repairs in the house	-.759	-.871	-.804
Raising/feeding of backyard animals	.041	.065	.051
Gardening	.086	-.020	.044
Attending barangay activities/affairs	.250	-.077	.120

Note: An index of 1 indicates that the wife is completely responsible for the given task. On the other hand, an index of -1 indicates that the husband is completely responsible for the given task. An index of 0 indicates that both wife and husband are equally responsible for the given task or somebody else, other than the wife or husband, is responsible for the given task.

The empirical estimates of the model are shown in Tables D7 and D8. In addition, Table D8 includes a regression equation with hours spent for income-generating activities as the dependent variable to compare the relative effects of the independent variables on the number of hours that women spend for domestic work vis-à-vis the number of hours that women spend for work to generate income.

The regression results in Table D7 indicate that having children under five years of age significantly increases the number of hours that women spend for household work. This result confirms the findings of earlier studies that the burden of caring for young children falls mostly on women. Thus, a larger family size will likely increase the work burden of women at home, even if these women are also engaged in market work outside the home.

The results in Table D7 also indicate that women in formal and informal sector work spend less time working at home compared to women who are "full-time" housewives. This is expected since the time availability of women in the formal and informal sector to do household chores is considerably less than women who are "full-time" housewives. One exception to this generalization, however, is the result in Table D7 which indicates that for the rural sample, the variable pertaining to work in the informal sector is not significant (although the sign follows the hypothesized relationship between type of work and number of hours spent working at home as indicated earlier). This suggests that rural women who work in the informal sector do not significantly spend less time working at home compared to rural women who are "full-time" housewives. A likely explanation for this result is that the location of informal sector work for women in the rural areas is relatively close to their homes (if not within their homes), which makes this type of work strongly compatible with domestic work.

The results of the variables on years of schooling in Table D7 indicate that, holding other things constant; an additional year of completed schooling increases the number of hours that women spend for domestic work. However, the effects of these variables are not significant in the regression equation for the rural sample. Nevertheless, the data suggests that women with more schooling will likely be occupied with more domestic work compared to women with relatively less years of completed schooling. A possible explanation is that more education will compel women to engage in more time-consuming hobbies at home such as orchid raising or maintenance of higher standards in household and childcare tasks.

The presence of a household help significantly decreases the number of hours that urban women spend for domestic work. However, Table D7 shows that this result does not hold for the rural sample. This exception is difficult to explain because common sense would dictate that the presence of a household help will significantly lessen the workload of women at home. However, a check of the figures in Table D1 offers the explanation that the result for the rural sample may perhaps be due to the fact that very few women in the rural sample have maids or servants (only 39 have servants), which will likely increase the chances that results pertaining to the variable, presence of a household help, will be insignificant for the rural sample.

The "contraception" variable in the equations in Table D7 is not significant in the three equations. Anyhow, it would be interesting to see how this variable will turn up if the model that is used in this study is applied to a bigger sample. [3]

Table D7. Estimates of Hours (worked at home) Equations for the Women in the Sample Area by Stratum: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996

Dependent variables: hours worked in a day			
Variables	**Urban**	**Rural**	**Urban & Rural**
Number of children under 5 years old	0.88	0.51	0.75
	(7.56)**	(2.82)**	(7.58)**
Residents in the household aged 5 and over	-0.06	0.07	-0.05
	(-3.1)**	(0.736)	(-2.62)**
Years of schooling completed	0.443	0.24	0.31
	(2.61)**	(1.55)	(2.93)**
Square of years of completed schooling	-.021	-0.01	-0.01
	(-2.60)**	(-1.39)	(-2.87)**
Whether living in urban or not	___	___	-0.16
			(-0.68)
Whether living in depressed area or not	___	0.21	0.13
		(0.62)	(0.66)
Whether living in tribal area or not	___	0.68	0.63
		(1.58)	(1.62)
Age	-.036	-.068	-0.04
	(-2.40)*	(-2.46)	(-3.10)**
Whether in formal sector or not	-.3.34	-2.78	-3.17
	(-6.45)**	(-2.74)**	(-6.70)**
Whether in informal sector or not	-1.33	-.644	-1.12
	(-5.25)	(-1.64)	(-5.21)**
With household help or none	-0.94	0.89	-.32
	(-2.49)*	(1.37)	(-0.98)
Has used contraceptives or not	0.102	-0.18	0.03
	(0.408)	(-0.54)	(0.14)
Total monthly income of husband	3.4E-05	4.6E-05	3.5E-05
	(1.52)	(1.066)	(1.70)
Constant	4.7682	6.7225	5.8324
	(4.61)**	(5.889)**	(8.070)**
R^2	0.18991	0.0675	0.1300
F	23.18**	3.90**	18.93**
Size of sample	1,000	660	1,660

Notes: (*) indicates significance at the 5 percent level. (**) indicates significance at the 1 percent level.
T ratios in parenthesis. Regression equations were computed using SPSS.

[3]The 'contraception' variable that is used in the model cannot further be categorized into frequency or seriousness of use of a method because the respondents in the survey were asked only whether they had used a method before or whether they are currently using a method.

The results in Table D8 indicate that having children under five years of age significantly reduces the number of hours that women spend for market work. This result is consistent with the findings of Adair et. al, 1996, which showed that the effect of childbearing on earnings was partly influenced by the number of hours worked, with each additional child associated with a decline in hours worked.

Table D8. Estimates of Hours Equations for Women in the Sample who are Engaged in Income-Generating Activities (Women who are not full-time housewives): Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996

Dependent variable		
Variables	**Hours worked at home in a day**	**Hours spent for income-generating activities**
Number of children under five	0.46	-0.40
	(2.36)*	(-2.38)*
Residents in the household aged five and over	-0.13	-0.02
	(-.14)	(-.25)
Years of schooling completed	-0.043	0.10
	(-.21)	(.56)
Square of years of completed schooling	2.7E-04	-.004
	(0.027)	(-.44)
Whether living in urban area or not	-.082	0.63
	(-2.24)	(2.04)*
Age	-0.06	0.02
	(-2.23)*	(0.90)
Whether in formal sector or not	-1.95	1.76
	(-3.99)**	(4.22)**
With household help or none	-0.38	1.13
	(-0.75)	(2.62)**
Has used contraceptives or not	-0.08	-0.37
	(-.20)	(-1.11)
Total monthly income of husband	2.3E-05	1.1E-04
	(.91)	(4.82)**
Constant	7.9187	3.3100
	(5.22)**	(2.57)*
R^2	0.1210	0.2125
F	5.43	10.66**
Size of sample	406	406

Notes: (*) indicates significance at the 5 percent level. (**) indicates significance at the 1 percent level.
T ratios in parenthesis. Regression equations were computed using SPSS.

Conclusion

The study finds that the women in the sample spend a significant portion of their daily schedule on domestic work, even if they are employed. The study also finds that the women spend a huge chunk of their time on the following childcare and home production activities: taking care and feeding of children; cooking and preparing of meals and snacks; washing and ironing of clothes; and cleaning of the house. Among these four activities, the number one activity in terms of time

consumption is “taking care and feeding of children.” Consequently, these results are consistent with the results of many past studies which indicate that even if women are involved in market work, they still spend a considerable amount of time on domestic work relative to men. The results are also consistent with the findings of earlier studies which indicate that women in developing countries spend a large portion of their time on childcare and home production activities.

The study also supported the hypothesis that the amount of housework increases as the number of children increases, particularly when the children are young. For instance, the study finds that the number of hours that the women in the sample spend for housework increases as the number of young children (children under five years of age) increases. The study also finds that the number of hours that the women devote to paid work decreases as the number of young children increases. This particular result is consistent with the findings of Adair et. al, 1996 which showed that “the effect of childbearing on earnings operated partly through hours worked, with each additional child associated with a decline in hours worked.” This latter result, however, is not totally in agreement with the results of the focus group discussions that were conducted in the study where it was found that the desire of women to do paid work (if they are not working outside the home) or to do more paid work (if they are already working) increases as the size of the family increases. Accordingly, there can only be one explanation for these seemingly contrasting results. That although a larger family size increases the desire of women to do paid work (or to do more paid work), the resulting additional household burden that comes from having additional children effectively prevents women from realizing this desire to do paid work (or to do more paid work).

Recommendation

To reduce the work burden of women at home, men should be encouraged to do more housework. Not only this, they should also be encouraged to take on their share of pleasant and unpleasant jobs at home, thus foregoing their tendency to leave the unpleasant tasks to their wives.

In addition, government authorities must initiate programs that will provide for day care services for small children so that women with small children will have more opportunities to do market work. Health and family planning authorities should also implement effective and efficient family planning programs. Consequently, the benefits of these programs should help reduce the work burden of women at home.

E. Contraceptive Failure in Northern Mindanao: Results from a Population-based Survey

This paper provides evidence about contraceptive failure in Northern Mindanao from a survey of 1,253 women who were using various contraceptive methods. The survey was undertaken by the

Research Institute for Mindanao Culture (RIMCU) of Xavier University as part of the women's studies project of Family Health International (FHI).[4]

The issue of contraceptive failure in Northern Mindanao needs to be explored because, unlike those in developed countries such as the United States, very few studies have investigated the reasons for contraceptive failure in the Philippines. Most researchers are wary of dealing with this issue largely because of the difficulties encountered in obtaining information pertaining to contraceptive failure and in measuring contraceptive failure rates. It is also more difficult to obtain funding support for studies of this nature from private and government sources as projects on the environment or the economy currently receive more attention and assistance. This situation is unfortunate because information pertaining to contraceptive failure is crucial to the implementation of family planning programs. For instance, if the study reveals that a certain contraceptive method is ineffective because of improper usage, such information can be the basis for strengthening programs by emphasizing correct method-use.

This paper aims to inform family planning authorities about the failure rates of different contraceptive methods to aid them in deciding which contraceptive methods should be recommended to women or which contraceptive method should be given funding support. This paper also aims to determine the reasons why some contraceptive methods are not as effective as others or why they do not work as well in the Philippines compared to contraceptive use in other (more developed) countries.

Defining and Measuring Contraceptive Failure

Most measures of contraceptive failure indicate a relation between exposure to the method and the risk of failure. Some studies measure the rates of contraceptive failure by comparing the failure rate for a particular method with the pregnancy rate for no method. However, this method ignores the likelihood that those who do not use a method are those who have low fecundity, and so their experience cannot be used as the hypothetical pregnancy rate among method users if they were to stop using.

The failures that are counted in the measures usually depend on how the concept of failure is defined. One such concept is that of extended failure which requires that all unintended pregnancies after use of a method should be counted as a failure even if use had been terminated prior to the pregnancy (see Ryder, 1973). This concept, however, is not commonly used because many researchers prefer to count failures attributed to actual use separately from failures that happen after use is terminated.

Another concept of failure is actual or use failure, which counts as failures all pregnancies that occur while a couple considers themselves to be using the method (see Tietze and Lewit, 1968). The use of this concept presupposes that failures that occur due to improper use must also be counted as failures. However, the use of the concept is partly subjective because it requires that women must determine whether their pregnancies occurred while using the method.

[4]The survey actually had 1,660 female respondents. However, only the results for 1,253 respondents who have used or tried or are currently using a contraceptive method are analyzed here because these women are the ones who have been exposed to the risk of contraceptive failure.

To derive a pure measure for method failure (also known in the literature as theoretical failure) many researchers exclude in their counts of failures those failures that are attributed to improper use of the method (see Tietze, 1971). This procedure, however, is likely to suffer from subjective and computational errors. For instance, if the information on failures is based on a survey, it is likely that some women will erroneously report failures due to improper use as method failures. Moreover, if failures attributed to improper use are excluded, this exclusion must be properly accounted when computing exposure rates. However, since it is difficult (and in many instances, impossible) to compute exposure rates that are adjusted for non-inclusion of failures due to improper use, the results will likely be unreliable in many instances. This unreliability is evident in the results of many studies which have shown very wide variance when reporting method (or theoretical) failures.

The Pearl Index

Two methods have been used in the literature to compute contraceptive failure rates. The first is the Pearl index (Pearl, 1932), which is computed as 100 times the ratio of failures to exposure measured in woman-years. Although the measure is easy to compute, it can be misinterpreted easily. Moreover, because failure rates typically decline with duration of use, the Pearl index as a summary measure is more prone to errors with a longer study period.

In order to avoid the problems associated with the Pearl index, a procedure using life table methods has been used as an alternative for computing failure rates. This procedure calculates a separate failure rate for each month, which are then chained together to yield the cumulative proportion conceiving within *x* months (Potter 1966). Studies commonly publish 12-month report rates, but on occasion 6-, 18-, and 24- month rates are also reported. Although these rates are easy to interpret, the procedure itself has the drawback that it cannot be computed if monthly failure rates are not available.

To obtain information about failure rates, the interviewers asked the women respondents the following questions: What family planning method are you using? Did you get pregnant while using this method? How many times did you get pregnant while using this method? How long did you use this method? However, the study uses the Pearl index instead of the life table procedure in computing failure rates because the foregoing set of questions do not provide information pertaining to monthly failure rates. Moreover, the study utilizes actual failures in the indices rather than theoretical failures because the answers given by the women do not provide reliable information on theoretical failures. Although the women in the survey were also asked if they thought that pregnancies were either caused by failure of the “method” or “improper use,” it was established later that many women subjectively classified as method failures those which they considered a result of improper use of the method.

Consequently, since the computed indices cannot be used to ascertain pure method failures, these are used alternatively as a means of comparing failure rates between different methods and

relating these rates to those obtained by other studies. The indices are also used to verify if there is truth to earlier claims by women organizations that improper use of methods is one of the problems that severely hampers the effectiveness of contraceptive use in Northern Mindanao.

Results from the Survey

The figures in Table E1 indicate that the pill is the most widely tried (or used) contraceptive among the 1,253 ever users who were covered in the study. The pill had been tried by 480 women (or roughly 38% of the total number of 1,253 women.) This was followed by the IUD (29.8%), calendar (23.6%), withdrawal (14.4), tubal ligation (8.7%), and condom (6.6%).

The results in Table E2 indicate that tubal ligation and injection (depo provera) are the most effective methods of contraception that were tried (or used) by the women in the study. Injection has a Pearl index of 8.9 while tubal ligation shows a ratio of failures to number of women of 1 failure for every 54.5 women. These two methods were followed by the pill, IUD and calendar with Pearl indexes of 19.1, 19.5 and 32.0 respectively. The most inefficient methods are condom, withdrawal and breastfeeding with indexes of 76.7, 47.0 and 43.3.

Discussion

The result which indicate that the pill and the IUD are the most widely tried (or used) contraceptive method among the women in the study is consistent with published reports which have shown that the pill is one of the most preferred contraceptive method by women in the Philippines. It is also consistent with family planning statistics in Northern Mindanao which note that the IUD is quite popular among women users in this region.

The results which show that the two most ineffective methods are condom and withdrawal are also consistent with the findings of previous studies that such male-controlled contraceptive methods are less effective compared with female-controlled methods such as the pill.

However, it appears that efficiency is not the main consideration for choosing a particular method since the two most effective methods namely, tubal ligation and injection, did not even rank in the top five of the most widely used contraceptive methods among the women in the study.

The Pearl indices in the study are relatively higher than the results of studies made elsewhere. For instance, as summarized in Trussel and Kost (1987), the highest Pearl index for the pill (among the 14 studies whose findings were summarized) is only 10.45, which is very much lower compared to the 19.1 recorded in the study. In the case of the condom, the highest index reported in Trussel and Kost (1978) is 13.8 while Table E2 shows that the Pearl index for condom is 76.7. Consequently, since theoretical failures are not supposed to vary widely from setting to setting, the big differences between the Pearl indices in the study and those recorded in other studies can only mean that failure rates in the study are caused mostly by improper use rather than by “method failure.” This conclusion is further supported by the results in Table E2 which indicate that a big portion of the failures have been directly attributed by the women as being due to

improper use. For example, out of the 147 failures that were reported for the pill, 64 failures had been attributed to reasons associated with improper use. In addition, the results in Table E2 which indicate that the two most efficient methods of contraception are tubal ligation and injection also lend credence to the foregoing explanation because these two methods are not likely to fail from improper use because they are not repeatedly used or administered. Thus, it is highly likely that the low indices for these two methods is an indication that the users of these methods were not faced with the usual problems of improper use that have plagued the other methods. An exception, however, is the IUD, which is supposed to be a method that requires little in terms of personal maintenance, but which shows an index of 19.5 while the highest that is recorded in Trussel and Kost (1978) is only 3.1. Consequently, the very high index for the IUD can also be an indication that the IUD failures in the study may not only be due to improper use but also due to improper insertion of the IUD, a situation that suggests that the quality of services provided by family planning providers in Northern Mindanao is far from satisfactory.

Table E1. Type of Contraceptive Method used by the 1,253 Women in the Sample Who Have Used A Contraceptive: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996

Contraceptive Method	Number	Percentage	Rank
Pill	480	38.3	1
IUD	373	29.8	2
Injection (Depo Provera)	43	3.4	
Diaphragm	0	0.0	
Foam tablets, jelly or aerosol	2	0.2	
Condom	83	6.6	6
Tubal ligation	109	8.7	5
Vasectomy	4	0.3	
Temperature	2	0.2	
Calendar	296	23.6	3
Symptoms	8	0.6	
Breastfeeding, Lactational Ammenorrhea Method (LAM)	35	2.8	
Withdrawal	180	14.4	4
Other methods (includes abstinence and herbal contraceptives)	28	2.2	

Note: The figures under NUMBER sum up to more than 1,253 because there are some women in the sample who have used (or tried) more than one method.

Table E2. Rates of Failure Experienced by the Women in the Sample Who Have Used a Contraceptive Method: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996

Contraceptive Method	No. of failures perceived as method failure	No. of failures from other reasons	Total failures	Years of use of Number of women	Pearl Index
Pill	83	64	147	767.42	19.1
IUD	54	15	69	353.58	19.5
Injection (Depo Provera)	2	0	2	22.33	8.9
Diaphragm	---	---	---	---	---
Foam tablets, jelly or aerosol	---	---	---	---	---
Condom	35	8	43	56.08	76.7
Tubal ligation	0	2	2	109**	1:54.5**
Vasectomy	---	---	---	---	---
Basal Body Temperature (BBT)	---	---	---	---	---
Calendar	138	56	194	605.17	32.0
Symptoms	---	---	---	---	---
Breastfeeding, Lactational Ammenorrhea Method (LAM)	12	6	18	41.58	43.3
Withdrawal	60	51	111	236.33	47.0
Other methods (includes abstinence and herbal contraceptives)	78	51	129	360.00	35.8

Note: The figures for vasectomy, temperature, symptoms, diaphragm and foam tablets were not included because there were very few women who were using these methods which render the resulting Pearl indexes very unreliable.
** number of women.

Recommendations

Since it is evident from the foregoing explanation that improper use is the main reason for contraceptive failure, health authorities and family planning providers should ensure that users be taught how to use family planning methods correctly. Family planning providers should also improve the quality of their services and consult with users regularly, to make sure that the methods are used correctly. Moreover, in view of problems associated with improper use of the methods, family planning authorities should also initiate a campaign to increase use of injectables or implants (such as NORPLANT) among married women or to encourage women who are interested or are using contraception to consider tubal ligation as an alternative method. Since implants are expensive, government authorities should consider subsidizing a portion of the cost of implants so that women, especially the needy ones, will be able to afford this form of contraception.

Lastly, health and family planning authorities should initiate a campaign to increase the awareness of men in Northern Mindanao that contraception is not the sole task of women but something that requires the full cooperation of men as well. This is in response to the study's

finding that male-controlled methods are less effective compared to female methods, a clear indication that many males in Northern Mindanao still do not think that contraception demands the full commitment of both husband and wife and is the responsibility of both.

F. Power Relations in Filipino Households: The Case of Southern Philippines

Rationale

Power relations in Filipino households have been the subject of investigation of a few studies in recent years. The findings of these studies generally suggest that the economic model advocated by Western feminists and resource theorists does not apply to this country. For instance, it was found that fertility is an important factor in power allocation in the Filipino household. Women with a large number of children were found to have more power in resource allocation and fertility decisions compared to women with a smaller number of children. As a result, these studies caution that the promotion of programs that limit family size could lead to the disempowerment of the married Filipino in their own homes (e.g. Alcantara, 1990).

It is the objective of this study to examine power relations in Filipino households in Southern Philippines to see if the findings of earlier studies also hold true for these households. It is important to reexamine the results of earlier studies because these have immense impact on the ongoing efforts of many concerned sectors of Philippine society to promote greater equity in Filipino households and to support programs that lead to reduced family size for married couples.

Decision-making in the Household: A Conceptual Framework

Three perspectives have been used frequently in the study of power relations in the household. The first, the resource-power perspective looks at power relations in the household within the context of how the individual resources of the husband and wife (e.g. earnings, education, occupation) are brought to bear in bargaining over who gets to decide over which in the household. This theory has since been reexamined a number of times, with recent studies focusing on which resources are important and how these resources may be used to enhance the husband’s or wife's control of decision-making in the household. Some studies also suggest that the value of the wives' resources may be “discounted” because of male dominance at the societal level (e.g. Ferree, 1991a).

Another theory is the time availability perspective. This theory assumes that decision-making in the household is a product of a rational process wherein husband and wife both consider their efficiency in doing things and the available time that they have for doing things. Whoever is doing more paid work is expected to be less involved in household chores because he or she would have relatively less time for such compared to the other (Coverman, 1985; Presser, 1994).

The third one is the gender perspective. This theory suggests that the workings of the household is a result of years of intensive socialization about what society expects to be the appropriate roles for men and women. Husbands’ and wives’ roles are thus based on what they have learned

and have come to believe about appropriate behavior for men and women (Shelton, 1992; Goldscheider and Waite, 1991).

The concept of “doing gender” has lately been incorporated into the “gender” perspective. Berk (1985) used this concept to describe the marital household as a “gender factory” which “produces” gender in the form of everyday housework and decision-making that mirrors the enactment of dominance, submission and other behaviors symbolically linked to gender.

Studies which have used the preceding three theories to guide their research about power relations in the household have produced mixed results, although the general consensus is that much more variance is explained by the gender perspective (see Ferree, 1991b, South and Spitze, 1994). A number of studies have also questioned the assumptions of the first two theories, citing that the results of most studies appear to refute these assumptions. First, they argue that decision-making in the household is hardly governed by rules of efficiency. Second, gender is more influential than individual resources in determining “who gets, does, or says what, when and how” in the household. Third, many women do not consider differing to the wishes of their husband as “bad” but rather as an expression of love and affection (Ferree, 1991b).

The results of studies that have been done in the Philippines are more in tune with the predictions of the gender perspective than with the predictions of the other two theories. For instance, these studies have found that Filipino wives generally control the household budget whether or not they contribute to the household income. These studies have also found that Filipino women predominate in subsistence resource allocation decisions and matters affecting child-care (Alcantara, 1990).

Another important finding of these studies is that fertility is a key factor in Filipino household power allocation. For instance, Alcantara (1990) finds that the balance of power in Filipino households swings in favor of the husband in the case of childless couples. However, the arrival of children drastically changes the pattern, with the wife gaining dominance in surplus resource allocation decisions, and having almost full control of decisions concerning subsistence resource allocation. The wife's power in fertility decisions is also greater among couples with a large number of children. Consequently, these findings are important. Those suggest that programs like family planning should be implemented sensitively because reduced family size may lead to the disempowerment of the Filipino in her own home.

This study reexamines the relationship between fertility and power allocation in the households by coming up with some testable hypotheses based on the three models that were cited earlier. If it were true that fertility increases the relative power of women in certain areas of decision-making in the household, then it is also possible that having more children will also increase the husband’s power in areas that are traditionally dominated by men (such as the buying of expensive things for the family or the buying and selling of family assets) because of the act of having children can be viewed as the wife’s unconditional acceptance of the roles prescribed by “gender.” Moreover, if “gender” prescribes that it is the wife's role to take care of children then having more children will increase the wife's power in resource allocation because the needs of children such as food and clothing usually consume a good portion of the family budget.

However, since child-rearing is also a time intensive activity, then it would be good to ask if the relative increase in power that women gain from having more children will be greater than the power that they would have gained in some other way, had they used the time they spent in taking care of children for some other activity such as paid work or getting more education.

This study examines also the relative impact of the use of family planning on the balance of power in the household. If a woman's use of family planning is to have an impact on the balance of power in the household, then it must be interpreted relative to the "gender" approach because it is clear that the other two approaches would not apply. The use of family planning per se does not increase a woman's resources nor does it provide her with more efficiency in deciding on things that have nothing to do with family planning. Consequently, if gender norms dictate that a woman's role in life is to stay at home and to bear children, then use of family planning by a woman can be viewed as a challenge to the traditional dictates of "gender." The use of family planning, together with its desired objective of preventing unwanted pregnancies, is in itself a form of resistance to the idea that a woman's role in life is merely to procreate.

Indeed, if the use of family planning is a form of resistance to traditional gender norms then we would expect a woman who uses family planning to resist, in some degree, other manifestations of gender which may include, among others, behavior that is traditionally associated with submission and male dominance. Thus, we would expect women who use family planning to have more power in the household relative to non-users because the former's use of family planning enables these women to do away, at least to some degree, with the dictates of "gender." Moreover, it is possible that women who use family planning may also tap their newly-found abilities (to resist the dictates of "gender") to further enhance their power in areas of decision-making that are traditionally female-dominated (such as what to market or cook for the family and what to do when children are sick).

Empirical Results

The findings of our study suggest that much of the power relations in Filipino households can be explained by the gender perspective. However, the study also finds that some of the variance in the differing levels of power between husband and wife in household decision-making can be explained by the resource-power perspective.

Patterns of Decision-making. The decision-making process involves an interplay of the decision problem, the decision-maker and the authority and influence (Safilios-Rothschild, 1970). The last two are power dimensions; however, they differ in terms of power source. Authority is legitimated and culturally prescribed. It is the right to make decisions and to dominate the decision-making process. Influence as a dimension of power emanates from the individual's own abilities, skills or other personal characteristics.

Decision problems are courses of action and are grouped here into three major categories: decisions related to children, decisions related to economic concerns, and those concerning socio-cultural and family relations.

On decisions related to children on what family planning method to use, and on the manner of care giving (Table F1), the decision-maker is the wife as affirmed by the majority of respondents. Although there are those who prefer that these courses of action be jointly decided, the figures suggest the influence of the wife because her decision has to prevail in case of conflict in preference. This implies that women themselves believe that with regard to reproductive needs, the men's involvement count and their decisions are sought. In case of conflicting ideas, though, it is the woman's choice that prevails.

Patterns toward egalitarian decision-making can be discerned in decisions regarding number of children to have, manner of child discipline, and what action to be done in case of sickness. This egalitarian decision-making presupposes communication between spouses and a rational balancing of options.

On matters of education and marriage, the authority to decide seems to be allocated to husbands by their respondent wives. Even for those wives who believe that there should be joint decision-making regarding what course the children will take or to which school children will be sent, it is the husband's influence that predominates.

In economic decision-making, the authority to decide on what to buy and cook, buying of personal items for basic grooming and whether or not to hire domestic help is given to the wife as claimed by the majority of respondents. Even for those who reported joint decision-making, the influence of the wife is demonstrated because her decision prevails.

However, decisions on purchase or sale of land, buying of consumer durables and household appliances are attributed to be the domain of husbands, including the decision whether the wife works outside the household or not. In these particular decision-making problems, the husband has both the authority and influence albeit discernible patterns toward egalitarian decision-making can be seen.

The pattern of decision-making is similar to the results of the Cebu Longitudinal Nutrition Health Survey (CLNHS). Women tend to make minor decisions but in decisions involving larger expenditures, the husband has a greater influence.

Table F1. Percent Distribution of Sample Respondents by Decision-Making: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Percentage of responses on who decides on the following activities:	Who Decides *					If both, whose decision prevails in case of conflict?	
	Wife	Husband	Both	Others	Undecided		
						Wife	Husband
A. Decisions related to children	23.7	28.4	45.3	0.3	2.3	44.6	47.0
- number of children to have	57.3	14.8	25.2	0.4	2.3	62.4	25.1
- family planning method to use	27.2	34.9	37.2	0.1	0.8	29.2	64.0
- discipline children	50.8	17.3	30.7	0.1	1.1	57.0	35.0
- what to do when children are sick	12.8	33.0	24.4	28.3	1.5	22.3	67.2
- course to take	18.3	31.1	20.8	28.5	1.3	23.4	64.0
- school to study	33.3	50.0	0.0	16.0	0.7	----	----
- choosing children's spouses	25.3	16.7	16.7	40.0	1.2	37.0	47.6
- friends of children							
B. Economic Decision-making							
- what food item to buy and cook	72.1	10.4	16.4	1.1	0.0	70.9	24.5
- buying appliances and expensive household items	15.6	38.8	43.8	0.6	1.2	24.5	69.0
- buying personal items/ grooming	73.7	11.5	10.0	0.4	4.4	35.3	25.4
- selling/buying family possessions (car, land, house)	10.1	52.4	35.2	0.3	2.0	12.4	77.7
- hire servants	56.1	25.1	16.3	0.1	2.4	50.5	29.2
- working outside the house	23.7	65.2	10.4	0.1	0.7	24.9	66.3
- giving assistance/support to in-laws (relations)	23.4	34.3	38.4	0.1	3.8	29.2	57.3
C. Social, Cultural and Family Relations Decision-making							
- initiates reconciliation after quarrel	18.6	74.9	5.1	0.0	1.4	17.4	56.0
- whose religion to prevail	51.2	20.7	12.2			----	----
- visit relations and friends	30.2	29.1	30.6	0.1	10.0	31.0	39.9

* Totals do not tally to 100 because of non-response

Giving of assistance and financial support to in-laws and relatives is either a decision of the husband or jointly decided upon. In case of conflicting interest, the joint decision can be overruled in favor of the husband's preference.

It is interesting to note that wives believe that the decision for reconciliation after a quarrel comes from husbands. Three out of every four wives expect husbands to woo and patch differences between them.

The majority of respondents claim that the decision on whose religion should be followed in the household is a wife's decision. Making social calls is equally shared by spouses or decided individually. The data seems to suggest that this particular activity does not entail control of one partner over the other.

Table F2 indicates that the wife's power in subsistence allocation such as what food to buy is generally higher in the rural case than in the urban case. The same pattern is true for husbands, wherein power over such tasks as who works outside the household, is also generally higher in the rural case than in the urban case. At any rate, these differences are consistent with the predictions of the gender perspective which includes, among others, that people in rural areas are more likely to adhere to traditional gender roles than those in urban areas.

Table F2. Decision-making in the Household: Mean Values of the Decision Index by Stratum (urban/rural). Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Decision Items	Mean		
	Urban	Rural	Urban & Rural
What food items to buy or who will cook for the family	.621	.797	.691
Buying of expensive things such as TV	-.312	-.312	-.423
Number of children to have	.069	-.256	-.060
What family planning method to use	.561	.432	.509
Giving of assistance and support to parents, in-laws, relatives, etc.	-.088	-.414	-.218
Whom to vote during elections	-.169	-.414	-.266
Visits to relatives and friends	.067	-.167	-.026
Buying items for personal grooming	.653	.591	.628
Selling and buying of family assets such as land, etc.	-.555	-.777	-.643
Who works outside the household	-.268	-.720	-.448
Hiring of servant or maid	.356	.274	.323
Who initiates reconciliation after quarrels or conflicts	-.613	-.533	-.581
Who disciplines the children	-.071	-.395	-.200
What to do when children are sick	.480	.256	.391
What course children will take or until what level of schooling will they be supported	-.250	-.392	-.307
The school that children will study in	-.167	-.265	-.206
Friends that children are allowed to go with	.101	.011	.065
Number of Cases	**1,000**	**660**	**1,660**

Note: An index of 1 indicates that the woman has complete control and power over the decision item. On the other hand, an index of -1 indicates that the husband has complete control and power over the decision item. An index of 0 indicates that wife and husband have equal control and power over the decision item or somebody else, other than the wife or husband, makes the decision.

The figures in Table F3 indicate that users of family planning generally have more power in the household than non-users of family planning. Although the regression equations in Table F7

indicate that only the results in "what family planning method to use," "how many children to have" and "hiring of a servant or maid" are significant, the pattern (in favor of family planning users) set in Table F4 may already be interpreted as significant in view of the fact that the study simply compared the non-users of family planning with those that had used family planning, not taking into account the fact that there may be some users of family planning who had used family planning for a very short period of time or who may not really be adherents of family planning in the sense that they are using very ineffective methods of family planning. Unfortunately, these distinctions cannot further be accounted for in the regression equations, but if they were, it is likely that more significant results will come out from the regression equations.

Table F3. Decision-making in the Household: Mean Values of the Decision Index by Ever-users and Non-users of Family Planning. Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Decision Items	Mean		
	Ever Users	Non-users	Users & Non-users
What food items to buy or who will cook for the family	.698	.674	.691
Buying of expensive things such as TV	-.410	-.470	-.423
Number of children to have	-.018	-.194	-.060
What family planning method to use	.572	.318	.509
Giving of assistance and support to parents, in-laws, relatives, etc.	-.186	-.319	-.218
Whom to vote during elections	-.254	-.306	-.266
Visits to relatives and friends	-.020	-.045	-.026
Buying items for personal grooming	.641	.594	.628
Selling and buying of family assets such as land, etc.	-.636	-.672	-.643
Who works outside the household	-.432	-.500	-.448
Hiring of servant or maid	.365	.196	.323
Who initiates reconciliation after quarrels or conflicts	-.587	-.567	-.581
Who disciplines the children	-.195	-.216	-.200
What to do when children are sick	.397	.376	.391
What course children will take or until what level of schooling will they be supported	-.287	-.371	-.307
The school that children will study in	-.190	-.256	-.206
Friends that children are allowed to go with	.066	.062	.065
Number of Cases	**1,255**	**402**	**1,650***

Note: An index of 1 indicates that the woman has complete control and power over the decision item. On the other hand, an index of -1 indicates that the husband has complete control and power over the decision item. An index of 0 indicates that wife and husband have equal control and power over the decision item or somebody else, other than the wife or husband, makes the decision.* 40 cases were dropped because of missing values

Table F4. Decision-making in the Household: Mean Values of the Decision Index by Level of Schooling of the Women in the Sample. Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Decision Items	Mean						
	0 - 5 Years	Elem. Grad.	7 - 9 Years	High School	11 - 13 Years	College Up	For All Women
What food items to buy or who will cook for the family	.746	.659	.709	.671	.714	.673	.691
Buying of expensive things such as TV	-.502	-.448	-.425	-.453	-.357	-.298	-.423
Number of children to have	-.211	-.146	-.098	-.036	.049	.155	-.060
What family planning method to use	.357	.448	.425	.614	.585	.629	.509
Giving of assistance and support to parents, in-laws, relatives, etc.	-.394	-.266	-.315	-.187	-.098	.048	-.218
Whom to vote during elections	-.479	-.403	-.248	-.218	-.116	-.107	-.266
Visits to relatives and friends	-.094	-.081	-.046	-.038	.049	.131	-.026
Buying items for personal grooming	.591	.532	.584	.691	.687	.714	.628
Selling and buying of family assets such as land, etc.	-.746	-.643	-.682	-.643	-.540	-.589	-.643
Who works outside the household	-.573	-.581	-.471	-.451	-.326	-.161	-.448
Hiring of servant or maid	.286	.182	.257	.326	.478	.554	.323
Who initiates reconciliation after quarrels or conflicts	-.577	-.536	-.636	-.583	-.634	-.500	-.581
Who disciplines the children	-.268	-.230	-.212	-.146	-.130	-.268	-.200
What to do when children are sick	.249	.380	.336	.444	.478	.458	.391
What course children will take or until what level of schooling will they be supported	-.352	-.331	-.379	-.293	-.242	-.190	-.307
The school that children will study in	-.253	-.201	-.257	-.204	-.156	-.131	-.206
Friends that children are allowed to go with	.009	.003	.052	.091	.170	.071	.065
Number of Cases	**213**	**308**	**327**	**417**	**224**	**168**	**1,660**

Note:

a) The women in the sample were divided into six educational categories: 0-5 years (women who did not finish elementary schooling); Elem. Grad. (women who only finished elementary schooling); 7-9 Years (women who did not finish high school); High School (women who only finished high school); 11-13 Years (women did not finish college); and Coll. up (women who finished college).

b) An index of 1 indicates that the woman has complete control and power over the decision item. On the other hand, an index of -1 indicates that the husband has complete control and power over the decision item. An index of 0 indicates that wife and husband have equal control and power over the decision item or somebody else, other than the wife or husband, makes the decision.

Nonetheless, these results clearly support the argument that the use of family planning has some "liberating" effect on women, to the extent that it is associated with attitudes that enable women to free themselves from the dictates of behavior that are closely linked with "gender."

The regression equations in Table F7 indicate that "wife's income" significantly increases the power of women in "the buying of expensive items for the family" and "the giving of assistance

and support to relatives." In addition, the equations indicate that "wife's income" significantly increases the influence of these women on other women as to "whom to vote for during elections."

The regression equations indicate that the "wife's education" is a key factor in the allocation of power in the household. Women with more education have significantly more power in deciding "what family planning method to use," "the number of children to have," "giving of assistance to relatives," "whom to vote for during elections," "buying items for personal grooming," "the school where the children will study," "the course the children will take and until what level of schooling will they be supported," "who works outside the household," "friends that children will be allowed to go with," and "hiring of a servant or maid."

Table F5. Decision-making in the Household: Mean Values of the Decision Index by Levels of Income (monthly) of the Women in the Sample. Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Decision Items	Monthly Income (in pesos)						
	0 - 500	501 - 1,000	1,001 - 2,000	2,001 - 3,500	3,501 - 6,000	Over 6,000	For All Women
What food items to buy or who will cook for the family	.690	.586	.701	.784	.756	.646	.691
Buying of expensive things such as TV	-.473	-.444	-.402	-.307	-.232	-.012	-.423
Number of children to have	-.098	-.061	.075	-.057	.061	.195	-.060
What family planning method to use	.488	.525	.561	.614	.476	.658	.509
Giving of assistance and support to parents, in-laws, relatives, etc.	-.270	-.323	-.187	-.079	.012	.272	-.218
Whom to vote during elections	-.323	-.252	-.215	-.091	-.049	.073	-.266
Visits to relatives and friends	-.057	-.040	.000	.136	-.049	.268	-.026
Buying items for personal grooming	.617	.677	.645	.682	.585	.695	.628
Selling and buying of family assets such as land, etc.	-.683	-.657	-.579	-.568	-.439	-.415	-.643
Who works outside the household	-.549	-.252	-.299	-.148	-.134	-.024	-.448
Hiring of servant or maid	.270	.333	.523	.534	.451	.476	.323
Who initiates reconciliation after quarrels or conflicts	-.581	-.556	-.645	-.625	-.366	-.695	-.581
Who disciplines the children	-.167	-.293	-.280	-.182	-.317	-.366	-.200
What to do when children are sick	.361	.545	.430	.523	.561	.280	.391
What course children will take or until what level of schooling will they be supported	-.334	-.353	-.336	-.159	-.183	-.085	-.307
The school that children will study in	-.223	-.172	-.290	-.091	-.158	-.061	-.206
Friends that children are allowed to go with	.057	.010	-.028	.216	-.012	.280	.065
Number of Cases	**1,202**	**99**	**107**	**88**	**82**	**82**	**1,660**

a) The monthly incomes of the women in the sample were divided into six categories to ensure that enough cases will fall in each category to facilitate comparisons between the mean of the decision index in each of the categories.

a) An index of 1 indicates that the woman has complete control and power over the decision item. On the other hand, an index of -1 indicates that the husband has complete control and power over the decision item. An index of 0 indicates that wife and

husband have equal control and power over the decision item or somebody else, other than the wife or husband, makes the decision.

Discussion and Implications

The foregoing results are clearly consistent with the results of previous studies which have established that in most Filipino households, the task of running the home is the wife's responsibility while paid work is the husband's responsibility. Women predominate in subsistence resource allocation decisions, whether or not they contribute to the household income.

The study also finds, consistent with the results of earlier studies, that the women have control over matters affecting childcare and that they are largely responsible for domestic chores such as cooking, cleaning, washing, and marketing tasks while men are largely responsible for such things as earning a living and house repairs. However, the study finds, contrary to the result of earlier studies, that fertility is not a key factor in Filipino household power allocation. For instance, the analysis does not show anything that would indicate that the balance of power in the household swings in favor of the husband in the case of childless couples.

The figures in Table F6 do not indicate any pattern that would support the argument that having more children increases the power of women in their respective households. This is clearly supported by the results of the regression equations in Table F7 which do not show anything that can be interpreted to mean that having more children significantly increases the power of women over a particular decision item. On the contrary, the regression results indicate that having more children significantly decreases the power of women in the following: buying of expensive items; and how many children to have. (A further examination of the results in Table F7, however, suggests that only the result pertaining to the "buying of expensive items" appear to be significant because the results pertaining to "how many children to have" may be influenced by large variations in the categories pertaining to women with more than six children where the cell counts are relatively small.) Anyhow, if the result on "buying expensive items" supports the argument that having additional children tends to reinforce "gender" in the household, why then did the other results not show that having more children increases the power of women in such areas as "what food items to buy or cook for the family" or "buying items for personal grooming?" A possible answer to this question in view of the results in Table F6 (which indicate very high positive values for the decision items, "what food items to buy or cook for the family" and "items for personal grooming") is that these items have been marked by "tradition" or by cultural factors as something that should be decided upon by women. These results suggest that any further increase in power that women may have over these items as a result of having additional children will likely be negligible because society has already decreed that women should take control of these items even if they do not have any children at all.

The results in Table F3 indicate that users of family planning generally have more power in the household than non-users of family planning. Although the regression equations in Table 7 indicate that only the results in "what family planning method to use," "how many children to have" and "hiring of a servant or maid" are significant, the pattern (in favor of family planning

users) set in Table F3 may already be interpreted as significant in view of the fact that the study simply compared the non-users of family planning with those that had used family planning, not taking into account the fact that there may be some users of family planning who had used family planning for a very short period of time or who may not really be adherents of family planning in the sense that they are using very ineffective methods of family planning. Unfortunately, these distinctions cannot further be accounted for in the regression equations, but if they were, it is likely that more significant results will come out from the regression equations. Nonetheless, these results clearly support the argument that the use of family planning has some "liberating" effect on women, in the sense that it is associated to a certain extent, with attitudes that enable women to free themselves from the dictates of behavior that are closely linked with "gender."

Predictably (and consistent with the resource-power perspective), the regression equations in Table F7 indicate that "wife's income" significantly increases the power of women in "the buying of expensive items for the family" and "the giving of assistance and support to relatives." In addition, "wife's income" significantly increases the influence of women on "whom to vote for during elections". The regression equations in Table F8 also indicate that "wife's education" is a key factor in the allocation of power in the household. The equations indicate that women with more education have significantly more power in decision items.

The results pertaining to the variables "wife's income" and "wife's education" clearly support the assumptions of the resource power perspective that decision-making in the household is also a process of bargaining between husband and wife wherein each one of them brings their individual resources to bear on the bargaining. However, the results also suggest that there are non-resource factors that effectively limit women from utilizing the full weight of their resources in this bargaining process. For instance, the regression equations in Table F7 indicate that "wife's income" and "wife's education" are not significant in "the buying and selling of family assets." Since the "buying and selling of family assets" is largely a "resource" decision, then it should be significantly affected by such resource variables as "wife's income" and "wife's education." However, since they are not, then only two explanations are possible. First, that the decision to "buy and sell family assets" is not subjected to bargaining but decreed by "gender" to be the man's prerogative. And second, that the decision to "buy and sell family assets" is subjected to bargaining but the wife's resources such as income and education are effectively "discounted" or ignored in the bargaining process.

On the whole, the findings of the study clearly suggest that much of the power relations in Filipino households can be explained by the gender perspective. However, the other results also give credence to the claim by resource theorists that some of the variance of the differing levels of power between husband and wife in household decision-making can be explained by the resource-power perspective

Table F6. Decision-making in the Household: Mean Values of the Decision Index by Number of Children of the Women in the Sample: Women's Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Decision	Number of Children								
	None	One	Two	Three	Four	Five	Six	Seven	All Women
What food items to buy or what to cook for family	.693	.719	.667	.675	.757	.615	.660	1.00	.691
Buying of expensive things such as TV	-.295	-.370	-.412	-.401	-.485	-.615	-.509	-.600	-.423
Number of children to have	-.023	.024	-.114	-.015	-.085	-.018	-.264	-.133	-.060
What family planning method to use	.500	.492	.430	.618	.511	.532	.509	.867	.509
Giving of assistance and support to parents, in-laws, relatives, etc.	-.136	-.217	-.231	-.180	-.230	-.303	-.302	-.267	-.218
Whom to vote for during elections	-.159	-.211	-.256	-.333	-.289	-.376	-.189	-.400	-.266
Visits to relatives and friends	-.125	-.021	-.062	.006	-.004	.000	-.020	-.133	-.026
Buying items for personal grooming	.614	.659	.651	.640	.579	.514	.679	.533	.628
Selling and buying of family assets such as land, etc.	-.534	-.673	-.636	-.590	-.664	-.807	-.679	-.733	-.643
Who works outside the household	-.398	-.449	-.453	-.375	-.536	-.514	-.472	-.333	-.448
Hiring of servant or maid	.148	.382	.276	.342	.370	.303	.472	.267	.323
Who initiates reconciliation after quarrels or conflicts	-.511	-.615	-.572	-.593	-.604	-.596	-.453	-.333	-.581
Who disciplines the children	-.045	-.120	-.177	-.280	-.289	-.211	-.207	-.333	-.200
What to do when children are sick	.227	.517	.370	.336	.396	.486	.302	.067	.391
What course children will take or when schooling will be supported	-.216	-.303	-.318	-.301	-.349	-.294	-.321	-.400	-.307
The school in which that children will study	-.057	-.183	-.235	-.236	-.221	-.174	-.113	-.533	-.206
Friends that children are allowed to go with	-.011	.024	.081	.080	.085	.128	.075	-.333	.065
Number of Cases	**88**	**327**	**481**	**339**	**235**	**109**	**53**	**15**	**1,660**

Note: a) The monthly incomes of the women in the sample were divided into six categories to ensure that enough cases will fall in each category to facilitate comparisons between the *mean* of the decision index in each of the categories.

Table F7. Estimates of Regression Equations Describing the Balance of Power and Control of Decision-making in the Household Between Wife and Husband: Women Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Decision	Number of Children	Wife's Schooling	Husband's Schooling	Living in Urban	Wife's Age	Husband's Age	Used Contraception	Wife's Income	Husband's Income	Constant	F	Cases
What food items to buy or what to cook for family	-0.19 (-1.60)	6.4E-04 (0.10)	0.007 (1.26)	-0.21 (-5.30)**	0.015 (4.58)**	-0.007 (-2.76)**	0.02 (0.58)	1.2E-07 (0.02)	3.6E-06 (0.86)	0.5390 (5.49)**	5.78**	1,660
Buying of expensive things such as TV	-0.038 (-2.60)**	0.01 (1.28)	-0.018 (-2.55)**	0.28 (586)**	0.001 (0.25)	0.003 (0.84)	0.07 (1.38)	1.9E-05 (3.04)**	-5.8E-06 (-1.11)	-06102 (-5.04)**	7.62**	1,660
Number of children to have	-0.036 (-2.27)*	0.017 (2.07)*	-0.01 (-1.20)	0.28 (5.37)**	0.004 (0.81)	7.2E-04 (0.19)	0.17 (2.97)**	8.1E-07 (0.11)	2.0E-06 (0.35)	-0.4956 (-3.71)**	7.35**	1,660
What family planning method to use	0.02 (1.51)	0.016 (2.29)*	0.005 (0.70)	0.057 (1.26)	-0.006 (-1.70)	0.003 (0.87)	0.22 (4.54)**	2.4E-06 (0.40)	-1.9E-06 (-0.38)	0.1732 (1.52)	5.93**	1,660
Giving of assistance and support to parents, in-laws, relatives, etc.	-0.009 (-0.56)	0.02 (2.61)**	-0.012 (-1.51)	0.27 (5.29)**	-7.2E-05 (-0.02)	0.005 (1.29)	0.10 (1.83)	1.8E-05 (2.69)**	-9.0E-07 (-0.16)	-0.7113 (-5.53)**	8.40**	1,660
Whom to vote for during elections	-0.006 (-0.49)	0.024 (3.89)**	-30E-04 (-0.05)	0.17 (4.30)**	0.002 (0.70)	-0.002 (-0.69)	0.012 (0.30)	1.8E-05 (3.45)**	-1.9E-06 (-1.86)	-0.5815 (-5.99)**	10.15**	1,660
Visits to relatives and friends	0.024 1.55	0.010 1.29	-0.006 (-0.79)	0.212 (4.15)**	0.002 (0.42)	8.8E-04 (0.25)	-0.023 (-0.43)	1.2E-05 1.73	1.6E-06 (0.28)	-0.3532 (-2.74)**	4.05**	1,660
Buying items for personal grooming	-0.006 (-0.53)	0.013 (2.00)*	0.003 (0.45)	0.01 (0.36)	-0.001 (-0.39)	6.7E-04 (-0.23)	0.035 (0.81)	1.1E-06 (0.20)	-1.4E-06 (-0.31)	0.5333 (5.19)**	1.55	1,660
Selling and buying of family assets such as land, etc.	-0.007 (-0.59)	0.004 (1.43)	-0.01 (-2.00)*	0.21 (5.36)**	-0.004 (-1.34)	0.006 (2.23)*	0.027 (0.51)	9.5E-06 (1.80)	1.2E-06 (0.29)	-0.8431 (-8.45)**	5.84**	1,660
Who works outside the household	-0.003 (0.19)	0.022 (2.94)**	-0.017 (-2.27)*	0.426 (9.01)**	-0.002 (-0.62)	0.004 (1.21)	0.025 (0.51)	1.1E-05 (1.70)	3.8E-07 (0.07)	-0.8633 (-7.25)**	14.34**	1,660
Hiring of servant or maid	-0.007 (-0.46)	0.026 (3.38)**	-0.02 (-0.34)	0.005 (0.10)	0.008 (1.93)	0.002 (0.51)	0.135 (2.60)**	5.0E-06 (0.76)	-4.0E-06 (-0.75)	-0.307 (-2.49)**	4.49**	1,660
Who initiates reconciliation after quarrels or conflicts	-0.002 (-0.18)	0.009 (1.25)	-0.007 (-1.05)	-0.09 (-2.04)*	6.8E-05 (0.02)	0.006 (2.11)*	-0.018 (-0.38)	-5.9E-06 (-1.00)	6.2E-06 (1.28)	-0.7801 (-7.01)**	1.84	1,660

Table F7 (continued). Estimates of Regression Equations Describing the Balance of Power and Control of Decision-making in the Household Between Wife and Husband: Women Studies Project. Cagayan de Oro City and Bukidnon Province, 1996.

Decision	Number of Children	Wife's Schooling	Husband's Schooling	Living in Urban	Wife's Age	Husband's Age	Used Contraception	Wife's Income	Husband's Income	Constant	F	Cases
Who disciplines the children	-0.016 (-1.04)	-0.002 (-0.28)	-0.007 (-0.92)	0.38 (7.29)**	-0.007 (-1.51)	-0.002 (-0.63)	0.035 (0.63)	-2.5E-05 (-3067)**	4.2E-06 (0.75)	-0.0099 (-0.08)	8.69**	1,660
What to do when children are sick	-0.006 (-0.41)	0.015 (1.96)*	-0.008 (-1.10)	0.22 (4.45)**	0.001 (0.32)	4.0E-04 (0.12)	0.004 (0.08)	-6.7E-06 (-1.03)	-2.9E-06 (-0.54)	0.1612 (1.30)	3.45**	1,660
What course children will take or when schooling will be supported	-0.02 (-0.15)	0.020 (3.10)**	-0.020 (-378)**	0.15 (3.57)**	-9.7E-04 (-0.27)	0.002 (0.61)	0.074 (1.67)	2.6E-06 (0.46)	2.6E-06 (0.56)	-0.4710 (-4.47)**	3.81**	1,660
The school wherein children will study	-0.012 (-0.93)	0.019 (2.85)**	-0.025 (-3.79)**	0.12 (2.71)**	0.006 (1.59)	-0.001 (-0.35)	0.061 (1.32)	-6.4E-06 (-1.09)	5.4E-06 (1.14)	-0.4198 (-3.81)**	3.28**	1,660
Friends that children are allowed to go with	0.020 (1.62)	0.013 (1.98)*	-0.011 (-1.82)	0.07 (1.82)	-0.005 (-1.36)	7.9E-04 (0.28)	-0.022 (-0.50)	7.4E-06 (1.35)	7.4E-06 (1.66)	0.0540 (5.02)**	2.31*	1,660

Note: a) T-values in parenthesis. (*) indicates significance at the 5 percent level. (**) indicates significance at the 1 percent level. Regression equations were computed using SPSS.
b) A positive coefficient suggests an increase of the wife's power over the decision item while a negative coefficient indicates otherwise.

Recommendations

To increase the influence of women in household decision-making, men should be encouraged to give women more opportunities to participate in decision-making. Government authorities can effectively help in realizing this objective by formulating policies and implementing programs that are gender sensitive. These programs should provide women with more and better work and educational opportunities. They should also provide women with more opportunities to participate in government affairs.

On the other hand, the private sector (including NGOs) can influence men to give women more opportunities to participate in household decision-making by implementing gender- sensitive policies and programs for their employees. Firm and NGOs should hire more female employees and give these female employees more opportunities to participate in their affairs.

G. An Inquiry on Social Construction of Concepts Related to Women's Concerns

As mentioned in the research methodology section, pre-survey FGDs were conducted to three groups of women: urban, rural and Muslim women. Results of the FGD provided input to the questionnaire construction.

Three major topics were covered by the discussion: the concept of work, leisure and rest; decision-making in the household; and effects of contraception on the lives of women.

Work, Leisure and Rest

The concept of work, leisure and rest are interrelated. Leisure is conceived to be a western idea. Rural people tend to be less time conscious because time is not considered as a resource. In order to elicit uncontaminated meanings which women attach to these concepts, the guide questions and the entire process were structured in a manner that generated responses that give meaning as well as define the boundaries of these concepts.

Work. To obtain a clear idea of their understanding of the concept of "work" the participants were asked to give examples of activities which constitute work. Further, they were asked if they were happy with the activities that they are doing, to see if work is associated with enjoyment or satisfaction. They explained what they meant by being "free from work" or "the conditions and circumstances that must be in place for them to feel that they are free from work." Questions on what they did during their free time enabled the investigator to contrast the activities that are considered as work and those that are not.

The results of the FGDs indicate that the three groups of women view "work" in the same light. Work is not only market work but also activities that have something to do with taking care of the household chores or tending to the needs of their children. Thus, aside from market work, they also consider as work the following: washing and ironing of clothes, taking care of children, cleaning the house, taking care of their husbands, cooking, gardening, etc. The

women's responses to the question of what to them is being "free from work" also indicated that they consider normal work in the household such as taking care of the children as part of their workload even if they are involved in some type of paid work. For example, the usual answers that were given about being "free from work" were: after lunch, nighttime, no free time, when children are asleep, when done with the household chores, etc.

Although the women in the FGDs are generally happy with the "work" that they are currently doing, it still appears that money is an important component of being happy in their work. Most of the women would like to work and earn money at the same time. Some of the answers that were given to support this include: "happy if I have the money"; "would like to earn while working"; and "no work, no money."

The answers of the women suggest that the primary effect of having more children is an increase in their workload since more children means more household work such as clothes to wash and food to cook. This hypothesis is clearly supported by answers such as:

> " I am always busy when the children are up."
> " I am only free from work when the children are asleep."
> " I can only rest when I am done with the household chores."

Moreover, it appears that a larger family size does not lessen the burden of the women to engage in productive activities that will augment the family income even if a larger family size entails a bigger work burden at home. This notion of a double burden for the women participants with large family sizes follows from their answers which indicate that, regardless of the size of their households, one of the primary goals is to engage in market work so that they will have the money to spend for their needs without taking it from their husband's earnings. As one woman remarked, "If the money is mine, then I do not have to consult my husband about the things that I need to buy." In addition, it appears that a larger family size increases the desire of women to do market work because more children necessitate a larger budget to support the needs of these additional members of the family.

Leisure. On the basis of an inquiry as to what constitute activities considered as leisure, the responses of participants showed that work and leisure are very closely related. Gleaned from the responses, the women's views indicate an overlap of work and leisure.

As examples, the following were given by participants (which were also mentioned earlier as work): gardening, taking care of plants, and doing household chores. Other answers that were given included: sleeping, attending to my things, time when I feel relaxed, reading, time to think or plan, look at my flowering plants, etc. The answers given by participants seem to indicate that work and leisure are strongly related when the activity that is involved provides enjoyment or happiness. As one participant stated, leisure is any activity that "I enjoy doing."

Rest. Rest is equated with leisure. Activities that were cited as "rest" were also previously mentioned as "leisure" which include the following: sleeping, time to relax, time to read, and working at things. Other answers that were given: time to be with husband, no work, no problems, watch TV, sit idly, Sundays when attending mass with husband, etc. Thus it seems clear to the women that "rest" is associated with the notion of cessation of action on activity such as "no work", "no problem" or plain relaxation.

Decision-making in the Household

A series of questions was asked to ascertain the balance of power in the household--who decides, who gets what, where, and when. This battery of questions include: "whose decision generally prevails in the household," "instances or conditions wherein the wife's decisions will prevail," "how the wife can influence her husband's way of thinking," "what are the things/activities which a wife can do without her husband's permission or approval," and "the status of the wife's relationship with her husband---whether she is on equal footing with him or not."

Whose decision generally prevails? The answers of the different groups indicate that in Muslim households, it is generally the man's decision that prevails. It appears that the dictates of culture, religion and tradition are such that the women in these households must adhere to the wishes of their husbands. Even if a woman feels that her husband's decision is wrong, she must accede to his decision/preference if he insists although she can somehow tell him that there is something wrong in his decision. As one Muslim woman said, "If I feel that my husband's decision or preference is wrong, I tell him so but if he insists on his decisions/preference then I have no choice but to accept it."

It appears also that the very same factors of tradition, culture and religion have left Muslim women with little power to influence their husband's way of thinking. This reality was summed up by one Muslim participant as follows: "I will just consult my husband. Tell him what I want. There are men who are easy to talk to and who give in easily."

On the other hand, the situation for the non-Muslim women (the women who composed the urban and rural groups were all Christians) is definitely better compared to Muslim women when it comes to decision-making in the household. A number of women from the non-Muslim groups said that decision-making in the household is a "joint undertaking." The following replies support this: "We both decide, we consult each other," "for major decisions we have to agree," "we discuss and jointly decide," "on major decisions, the husband decides but I have a way of manipulating it. Thus it would appear that he decides but it is my way that is generally followed. Decision on children (discipline, going out) is his; mine would be on financial aspects." However, men still have a bigger say on matters that are deemed important or have major consequences on the family. The women only get to decide freely on the minor matters but they must consult their husbands on matters that are not deemed minor. Nonetheless, it appears that the power of the women to decide increases if they have their own sources of income. Support for the foregoing hypotheses include the following answers: "Husband has to decide on major or important decisions," "If it is a matter which needs a man to decide, he

decides; if it is a matter which a woman has to decide, I do," "I decide if I am to pay." Moreover, it appears also that the women from these groups get a lot of leeway to decide on financial matters: "I do the budgeting--how to allocate my husband's earnings," "If it is about appliances I decide."

Another aspect about the situation of the non-Muslim women when it comes to decision-making in the household is that it appears that the women from these groups have very effective ways and means of influencing their husbands' way of thinking. These ways and means include "persuasion," "lying," "refusal to have sex," "persistence," and "show of irrational behavior." For instance, consider the following answers: "I decide on household matters. But if there is something I want to change in the decision, I will explain and persuade him (power of persuasion)." ; "If he will not listen to my explanation or be convinced, I pretend I'm angry. If I cannot convince him by pretending anger, I'll resort to gentle persuasion." ; "I'll lie. If I want something or need to acquire something I'll go ahead and buy. I'll not bring it home. I'll show the item later after I talk to him." ; "I go "wild" if my decision is not followed." ; "I try to explain the logic of my decision to my husband. I use "persuasion." ; "If he does not accommodate me now, I keep on insisting because he might relent later on especially if we will be economically better." ; "If I want it very much and he does not agree, I go "wild" and I do not let him sleep beside me and he cannot ask me to do anything for him." Consequently, this ability to influence their husbands' way of thinking somehow increases the actual decision-making power of the women (from the urban and rural groups) in their respective households.

Things that can be done without the husband's approval. The activities/things that women can do without permission from their husbands usually include the following: buying of small items for grooming, personal care and beauty items, buying items for household use, doing household chores, buying market items such as food. It appears also that the women will have more liberty to do certain things or activities if they spend money that they earn (rather than their husbands') for these activities/things. Answers that were given about activities/things that can be done without husband's approval include: "buying small items for household use"; "things for grooming, beauty items, personal care items"; "household chores, especially washing clothes"; buying market items (but you ought to know what your husband's taste is, what he likes)"; "exceptions are when items are expensive, then we have to consult our husbands"; "if the money is mine, then I do not inform my husband anymore, but if it is his, then I have to inform him"; "I can buy household needs like food or rice."

State of Relationship with Husband

Muslim women because of religion, tradition and culture, have to submit to their husbands. Their answers strongly support this: "We should always be "under" our husbands, so there will be not quarrels and no misunderstanding," "It is the law of our religion that women should submit to their husbands." Moreover, it appears that most Muslim women believe that there is nothing wrong with being submissive or being dominated by their husband. The women agreed that "We do not feel that it is wrong for a woman to submit to her husband."
Division of labor is strictly followed in Muslim households. The men are the ones who earn a living while the women do the household chores. For instance, consider the following answers:

"Division of labor is very strict among us--the men will be responsible for providing for the basic needs like rice while the women do the household chores."; "Tradition has it also that it will bring bad luck if a man helps a woman with the household chores or if a woman helps the man in his assigned tasks/roles." ; "There are some men who help in the household chores now but they are still rare." ; "We can ask our husbands to help us but we cannot insist--if he does not want to help then we must leave it at that."

There were a number of women in the urban and rural groups who indicated that they were satisfied with their relationships with their husbands. Their satisfaction is clearly showed in the following responses: "I feel we are equals."; "I think that the issue of who decides will depend on the situation or issue." "Equal, give and take, whichever decision generates more benefits."; "Equal, because we discuss and weigh the positive and negative results." However, it seems that the women in general do not like it when they end up doing all the work in the house without any assistance from other members of the family especially their husbands. It appears also that much of the feeling of burden of these women stems from the fact that they are not paid for the household work that they do. The following answers clearly reflect these sentiments: "I complain. I feel burdened with no pay."; "I don't like it when I do all the work in the house. A maid is better because she gets paid while I am not. I get my husband's salary but hardly a portion goes to satisfy my needs."; "I don't like it when my husband does not wake up early."; "I do tell my husband sometimes that I feel burdened with so much work. The usual reply is that he is also doing his best in his job."

Contraception

Questions asked of participants included "Whether contraception makes a woman feel guilty or in control of her life"; "Whether use or non-use of family planning (FP) is an expression of sexuality or can lead to a free discussion of sexual desire." Women were also asked how they are able to refuse the sexual advances of their husbands when they do not feel like having sex. Moreover, to determine the consequences of these refusals, interviewers posed a "probe" question in instances wherein they experienced some form of violence from their husbands as a direct consequence of their refusal to have sex.

Feeling of guilt and expression of sexual desire. Muslim women indicate that religion and tradition are the major reasons why most of the Muslim participants do not use FP. The results indicate that the religion of these women strongly prohibit them to use FP as the following responses indicate: "It is a sin to use FP, because a child will die and because for Muslims, a child is a blessing, and God already has a plan for the child even before he/she is born, and so must not be aborted or controlled." Restrictions on the use of FP are also imposed on the women by long-held traditions although it appears that use of "folk methods" is not prohibited. "There are women here who use the "roots" of a certain tree as a contraceptive if they do not want to have children. We do not look at them in a "bad" way because it is usual here." "What is not acceptable is if you control birth by taking medicines. So long as there are no medicines it is okay."

However, it seems that the burden of raising so many children forces some of the Muslim women to use FP even if they know that they will be "scorned" by the people in the community. Moreover, it is easier to decide to use FP if it has the blessings of the husband. "Even if they will scorn me, I cannot afford to have additional children, and that is why I use an IUD. Anyway my husband agrees." "So long as the husband agrees, then I guess one can practice FP."

Muslim women are not able to associate contraception with expressions of sexuality and sexual desire because of the prohibitions of their religion. It appears that their religion in general prohibits the women to talk about sex or to initiate sex as the following responses would indicate: "Women are generally ashamed to initiate the talking about sex. If the man starts it, then It's OK."; "We do not initiate sex because it is shameful for a woman to do so."; "We never knew anything about sex before we got married."; "Muslim women are bound by religion and tradition to behave in a certain way, that is why they cannot initiate sex. The women are respected by the men and the men are respected by the women."

Some of the reasons that were given by the women in the urban and rural groups why they refuse to use FP method include: prohibited by the church; fear of side effects; ineffectively of the FP methods; and unpleasant health effects. "I feel guilty (of FP) because it is prohibited by the church."; "We can never really be sure that we won't get pregnant if we are using the pill method because you might forget to take your pills once in a while."; "I was sort of "scared" when I was using pills because I heard that the method was not 100% safe and it had side effects."; "We can never really be sure that we will not get pregnant if we are using a family planning method because I had an IUD and I still got pregnant. In fact, I felt guilty that I got pregnant because I had an IUD."; "I was afraid to use FP because I heard that it has side effects."; "I discontinued using pills because my blood pressure would rise. At least if you get lots of children and you die, the children are evidence that you lived but if you die by pills you are very unlucky."

The answers given by the participants from the urban and rural groups clearly indicate that the most important benefit of FP is that it allows them to have fewer children or the number of children that they really want. The answers also indicate that the happiness that ensues from FP use stem mainly from the belief that FP will not result in unwanted pregnancies. "The main reason that we refuse is that we don't want to get pregnant especially if we have so many children already."; "It is really different if you are using FP because you have no fear of pregnancy."; "Since I started using pills, we can do it anytime."; "I enjoy sex more because I have no fear of getting pregnant."; "Family planning has really helped our relationship. I think FP is good."

Some of the women from the urban group indicated that they can discuss sex anytime with their husbands especially those who are using the calendar method and withdrawal method. "Since I use the calendar method, I tell him that I am fertile during the "unsafe" days. If he goes ahead to have sex, then he must "withdraw" it."; "We discuss sex anytime--it is not taboo to us." However, some of the women from the rural group indicated that they are ashamed to initiate or talk about sex. "With FP, I have no fear of pregnancy but I won't initiate sex."; "I won't initiate

sex because it does not seem right." Thus, it appears that urban women are more open to discussing sex than rural women.

How they convey refusal to have sex. The women are able to refuse sex by usually telling their husbands the following: they are tired; their body or head aches; they are sleepy; they are having their menstruation; or they promise to have sex later. "I tell him that I am tired, that my body aches or my head aches."; "Whatever he does, I just go to sleep."; "I tell him that I don't want to have sex. If he asks me why, I say that I am tired."; "I never agree to having sex when I have my "menstrual" period. If he insists, then I have to quarrel with him."; "I tell him that I have a headache."; I pretend to be sleepy if I don't want to have sex."

Some of the women indicated that they do not refuse to have sex with their husbands because it becomes a "source of quarrel." One woman indicated that she does not refuse her husband because of her fear that "He might satisfy his sexual needs elsewhere." A few women hinted that they are not able to refuse sex because of the possibility that their husbands may inflict harm on them if they refuse. "I do not refuse my husband anymore…there were times before when my panties were torn and garters were cut."; "I really do not cross my husband when he is drunk. It is for a couple to quarrel but I never argue with him when he is drunk."; "I make it a point to be calm when my husband is angry."

Chapter 4

Overall Summary and Recommendation

Rationale

The increasing realization on the dearth of studies and the need to look at how family planning affects women's lives triggered scientific ventures and investigations. Spearheaded by the Women's Studies Project (WSP) of Family Health International, inter-country studies were conducted by several academic institutions: the office of Population Studies (OPS), San Carlos University in Cebu City, the Social Science Research Institute (SSRI) of Central Philippines University, Iloilo City and the Research Institute for Mindanao Culture (RIMCU), Xavier University, Cagayan de Oro City. Each institution conducted the research study in partnership with a women's organization. In the case of RIMCU, the partnership was with the Women's Forum of Region 10.

Early research interests centered on examining and predicting factors influencing the decision and practice of family planning use. Such relationship was premised on the assumption that contraceptive methods are designed for women's use and reinforced by the cultural norm that family planning is a woman's responsibility.

In recent years, a new direction was set forth; family planning is viewed as an explanation directly or indirectly influencing changes occurring in women's lives.

The WSP conceptual framework described in the earlier sector, provides direction and format to the present study. While the overall objective is to investigate the effect of family planning use on women's lives, the specific objectives cover a wider scope and timely specific concerns of women, to wit:

1) To describe women's strategic and practical reproductive needs and how the use of a family planning method makes a difference in women's reproductive health.
2) To determine how family planning use is associated with the following areas of women's lives:

    - employment
    - household task allocation and domestic work
    - family roles and interpersonal relations

3) To measure contraceptive failure and determine possible explanations.
4) To examine the prevalence of domestic violence and its socio-economic, demographic correlates.

Methods And Materials

For a period of two and one-half years, the study covered urban and rural areas and utilized both qualitative and quantitative research modes. The latter consisted of a longitudinal follow-up survey of rural women in Bukidnon province and cross-sectional survey of urban women in Cagayan de Oro City.

The rural sample covered 660 ever married women of ages 15 to 49 years that were initially surveyed in 1994 under the UNICEF-funded Maternal and Child Health Study. These women were drawn from the sample frame of better and poorly-developed communities and from tribal barangays of the province.

The second sample of 1,000 urban women was selected using a two-stage clustered sampling procedure. The first stage involved selection of urban sample communities in Cagayan de Oro and the second stage was the systematic selection of households where married women ages 15 - 49 were taken as the unit of analysis.

The choice of urban and rural settings in the northern part of the Mindanao island provides the study with a timely opportunity to examine the changes in women's lives in areas that have recently experienced substantial economic growth and development. This is a result of the present government's efforts to develop the vast natural resources of Mindanao by opening up to local and foreign investors. Moreover, a comparison of urban and rural settings will give the study the chance to examine the impact of varying economic and cultural settings as they impinge upon women's concern.

The survey instrument include modules from the Women's Studies Project's (WSP) core questionnaire. Additional topics were included to obtain more detailed information on income, employment, time allocation, and domestic violence.

To supplement the qualitative data derived from both the longitudinal and cross-sectional surveys, Focus Group Discussion (FGDs) were conducted prior to and after the survey. Three sessions of pre-survey FGDs were conducted with urban, rural, and Muslim participants. Designed to provide input to the survey instrument, the FGD guide questions included topics pertaining to the following: rest/leisure, women's work, decision-making in the household, gender relation, and contraception.

A significant portion of the FGDs dealt with the concepts of work, rest and leisure. The questions were designed to provide information; thus participants were asked to give examples of activities which they considered work, whether they were happy doing such activities that they considered as work, and what being "free from work" means to them.
Five sessions of post FGDs were conducted among urban wives, urban husbands, rural wives, cultural minority husbands, and cultural minority wives. The qualitative results were incorporated in the data analysis. Topics included in the discussion were: unwanted pregnancy, task allocation, decision-making, domestic violence, and women's income.

To answer the objectives, the analysis generated separate and distinct topics. Statistical presentations include univariate, bivariate, and multivariate measures. Analysis of variance (ANOVA) and multiple regression were utilized.

This study follows the overall plan for dissemination of results from all the WSP projects in the Philippines. A "community feedback" segment is arranged to share results with local health providers, local officials and women respondents. Feedback sessions are conducted for rural and urban areas.

The Findings

Seven distinct analyses were prepared with the following subheadings:

a. Profile of Sample Households and Women Respondents
b. Family Planning Use: Making a Difference on Women's Reproductive Health
c. Correlates of Domestic Violence
d. Women's Work and Family Size: The Case of Southern Philippines
e. Contraceptive Failure in Selected Areas of Northern Mindanao: Results from a Population-Based Survey
f. Power Relations in Filipino Households: The Case of Southern Philippines
g. A Qualitative Inquiry on Social Construction of Work/Leisure, Power Relation, and Contraception

For a comprehensive and understandable presentation, findings of the study are discussed under the rubric of individual analysis.

A. Profile of Sample Households and Sample Women

Profile of Sample Households

- A differential in economic condition is observed between areas; tribal and depressed areas of Bukidnon are at a disadvantaged position in terms of:

    - per capita income
    - average monthly cash income
    - material possessions
    - household amenities

- Household ownership of goods indicates gender-bias against women. Practical gender needs of women are muted in favor of the need for entertainment. Thus, ownership of radio, TV, and cassette is preferred more than ownership of electric iron and refrigerator.
- Control of a major resource (land ownership) is evidently in the hands of the husband.

Profile of Sample Women

- Sample women are on the average, 32 years old; have attained a third year high school education; married at age 21; and Catholic. Women from tribal and depressed communities are disadvantaged in education. They marry younger than their urban counterparts.
- More than one-half (54%) of sample women are currently using a method. Preference is for modern methods. The most popular is the IUD followed by the pill and tubal ligation.
- Unwanted pregnancy had occurred to forty-six percent (46%) of the women under study.
- Household tasks are reported by women to be predominantly the wife's tasks. The responsibilities of earning a living and doing repair in the house are allocated to the husband. In addition to doing household work, a greater number of women compared to men attend community activities.
- Only one in every four women is engaged in market work; the rest are a full-time housewife.
- Husband's average monthly income is thrice more than the wife.
- Three out of ten women have knowledge on loan sources; those who venture to obtain a loan seek the husband's approval first.
- Working women indicated satisfaction in work albeit very few were provided with work benefits. Sick leaves, vacation leaves and maternity leaves were extended to one in every ten (10) working women only.
- Participation in community affairs is viewed to be beneficial for the following reasons: these keep them informed; they learn something or they learn personal skills; and these provide a way to spend leisure and enjoy the company of others.
- Majority of women affirmed their community involvement in church-related work, community development and health-related activities.

B. Family Planning Use: Making A Difference on Women's Reproductive Health

Economic And Social Differentials

- Never users live in houses with light materials, have smaller number of material possessions, and have lower average income compared with the ever users.
- Never users are slightly younger, have less years of schooling, and spend more hours in household work.
- Current users have better economic condition, they live in houses with strong materials, possess higher items of consumer durables, and have higher average income.
- Irrespective of family planning use or non-use, women have high satisfaction in life. High satisfaction is expressed in relation to their marriage, friends, and religion.

Reproductive Health Needs

Indicators of practical and strategic reproductive health needs are drawn from contraceptive and reproductive health knowledge (need for information-education), experiences of infertility and unwanted pregnancy, reproductive health services received and would like to receive (need for reproductive health services), and experiences with family planning health providers (quality of care).

- Overall, knowledge of different family planning methods is high except for modern natural family planning, withdrawal, and use of diaphragm and foam.
- Knowledge of family planning method is not spontaneous; women have to be prompted in method identification.
- Current users are more knowledgeable about family planning methods compared with the other two use-categories.
- An overwhelming majority of women relate reproductive health to the ability to bear children, the ability to choose the number of children, and physical and mental well-being. Few women do not consider "the ability to have satisfying sex" as falling under reproductive health.
- Close to one-third (31%) of never users have difficulty in conceiving; slightly lower percentages (25 and 11 percents) of current non-users and current users, respectively professed the same difficulty.

Among those who have difficulty in conception:

  - ♦ one out of every six never users cannot bear children primarily because they have reached the end of reproductive period.
  - ♦ one out of three current non-users cannot have a child because of voluntary infertility

- Overall, forty-six percent (46%) of women experienced unwanted pregnancy. However, variation between use-category is shown by the data. Never users have the least number of unwanted pregnancy while current non-users have the highest. The most common response is to accept the reality and let the child grow into full-term.
- One in every five mothers believed that the unwanted pregnancy has an effect in their lives, most notably stressful relation with husbands characterized by frequent quarrel, blaming, and other manifestation of anger. Economic difficulties, increase in domestic work, and psychological effects experienced by mothers are also noted. The latter include anxiety, worry, being scared and loss of weight. Only a very few observed the effect on the unwanted child.
- Across use-category, majority of women reported having received reproductive services connected with prenatal care, child health care and nutrition counseling.

- Data on services for reproductive tract infections suggest lack or inadequate services hence very few were able to avail. Only a negligible number (less than three percent) have received Reproductive Tract Infection (RTI) and Sexually Transmitted Diseases (STD) exams and treatment.
- The three most popular services which women would like to receive are pelvic and breast examination and pap smear.
- Never users are disadvantaged in comparison with the ever users with regards to utilization of reproductive health services.
- Family planning services are generally obtained from the public sector notably the Rural Health Unit (RHU).
- A large majority of women reported no problem with the most recent family planning services. However, for those who encountered problems, the most mentioned are shortage of supplies, clinic/source is far from their homes, and long waiting time.
- Family planning services considered as most important are user's friendly staff, clean clinics, and nearness to home.
- Women suggest that easy accessibility of family planning services, more information, longer clinic hours, and less expense would satisfy their needs.
- To perform breast exam, pelvic exam, pap smear, IUD insertion, and STD diagnosis, a female service provider is the preference of women. Majority of women in the study would refuse such services if given by male service provider however, tolerance is expressed for male provider giving injection and family planning counseling.

C. Correlates of Domestic Violence

Patterns of Domestic Abuse

- One in every four women in both areas (Bukidnon and Cagayan de Oro) reported being ever physically harmed.
- Among those who experienced physical abuse, nineteen percent (19%) affirmed the frequent repetition of the act.
- Physical abuse happens when the husband is drunk, during a quarrel or disagreement.
- Reasons cited are attributed to the husband that includes jealousy, gambling, having an affair with another woman, and being engrossed in "*barkada*" activities.
- Reasons attributed to the wife include refusal to have sex, negligence in caring for the children, leaving the house without the husband's knowledge, and difficulty in adjusting to husband's ways.
- Two-thirds of physical violence consist of single acts of abuse. Most common acts are punching, slapping and kicking.
- Severe (high index) physical and emotional abuse happens to 21 percent of women; more than one-third reported no experience of violence.

Correlates of Abuses

- Among the hypothesized correlates of domestic abuse, the following are significantly related to domestic abuse.

    - Women from urban areas tend to experience more incidence of domestic violence than their rural counterparts.
    - Husbands performing household tasks, specifically the cleaning and washing in the household, have the proclivity towards domestic violence.
    - Wives who make personal decisions on the manner of disciplining children tend to be recipients of domestic abuse.

D. Women's Work and Family Size: The Case of Southern Philippines

- The study reveals that women spend a significant portion of their daily schedule on domestic work, even if they are employed. This is consistent with the results of many studies in the past which indicate that even if women are involved in market work, they still spend a considerable amount of time on domestic work relative to men.
- The study finds that women spend a huge chunk of their time on the following childcare and home production activities: taking care of children and feeding them; cooking and preparing snacks; washing and ironing of clothes; and cleaning the house. Among these four activities, the number one activity in terms of time consumption is "taking care and feeding of children." This result is also consistent with the results of earlier studies that indicate that women in developing countries spend a large portion of their time on childcare and home production activities.
- The study finds that the number of hours that women spend for housework increases as the number of young children (children under five years of age) increases. This result is consistent with the hypothesis that, since childbearing is a time-intensive activity, the amount of housework will likely increase as the number of children increase, particularly when children are young.
- The study finds that the number of hours that women spend for paid work decreases as the number of young children increase. This result is consistent with the findings of Adair et. al., 1996, which showed the effect of childbearing on earnings operated partly through hours worked; each additional child is associated with a decline in hours worked.
- The results of the Focus Group Discussions suggest that a larger family size increases the desire of women to earn money (if they are not working) or to earn more money (if they are working). The FGD result is consistent with the hypothesis that a larger family size will increase the burden of women to do paid work (or to do more paid work) to add to the family income since more children will necessitate a larger budget to support the additional needs of a bigger family.

The results suggest that although a larger family size increases the desire of women to earn money (or to earn more money), the resulting additional housework burden that comes from having additional children effectively prevents women from realizing this desire.

E. Contraceptive Failure in Selected Areas of Northern Mindanao: Results from a Population-Based Survey

- The study finds that the pill and the IUD are the most widely used contraceptive methods among the women in the survey. The results of the study also indicate that injectables, tubal ligation, the pill and the IUD are the most effective methods of contraception that are used. On the other hand, the study finds that the use of the condom and withdrawal are the most ineffective methods of contraception that were used by couples covered in the study.
- The study also finds that contraceptive failure among the users is caused mostly by improper use of the method rather than by method failure. This finding is supported by the results of the survey which indicate that a big portion of the failures have been directly attributed by the women as being due to improper use. It is also supported by results which show that the two most efficient methods of contraception are tubal ligation and injection, methods that require almost nothing in terms of correct usage because these do not have to be repeatedly used or administered by the users from time to time.

F. Power Relations in Filipino Households: The Case of Southern Philippines

- Most of the findings of the study are consistent with the gender perspective (which suggests that husbands' and wives' roles are based on what they have learned and have come to believe about appropriate behavior for men and women). For example, the study finds that women predominate in subsistence resource allocation decisions whether or not they contribute to the household income. The study also finds, consistent with the results of earlier studies, that women have control over matters affecting child care and that they are largely responsible for domestic chores such as cooking, cleaning, washing and marketing tasks while men are largely responsible for such things as earning a living and house repairs.
- The study finds, contrary to the results of earlier studies, that fertility is not a key factor in Filipino households' power allocation. For instance, the analysis does not show anything that would indicate that the balance of power in the household swings in favor of the husband in the case of childless couples. It does not also reveal anything that would show that women with more children have greater dominance in resource allocation decisions compared to women with fewer children. In addition, the analysis does not show that the wife's power in fertility decisions is greater among couples with a larger number of children. On the contrary, the influence of women in decisions involving the buying of expensive items for the family such as TV decreases as the number of children increases.
- The study finds that users of family planning have more influence in fertility decisions and decisions involving "what family planning method to use" and "the hiring of a servant or maid" compared to non-users of family planning.

- The analysis finds that as the wife's income increases, her influence also increases in decisions involving "the buying of expensive items for the family," "the giving of assistance and support to relatives" and "whom to vote for during elections." Moreover, women with more years of schooling have more influence in household decisions involving "what family planning method to use," "the number of children to have," "giving of assistance to relatives," "whom to vote during elections," "buying items for personal grooming," "the school where children will study," "the course children will take and until what level of schooling will they be supported," "who works outside the household," "friends that children will be allowed to go with" and "hiring of a servant or maid" compared to women with fewer years of schooling. These two results are consistent with the assumptions of the resource power perspective that decision-making in the household is also a process of bargaining between husband and wife wherein each one of them brings their individual resources to bear on the bargaining. However, the study also finds that there are factors that appear to limit the power of women to fully utilize the weight of their resources in the bargaining process. For instance, the analysis indicates that "wife's income" and "wife's education" are not significant in "the buying and selling of family assets." Since the "buying and selling of family assets" is largely a "resource" decision, then it should be significantly affected by such resource variables as "wife's income" and "wife's education." Since they are not, then only two explanations are possible. First, that the decision to "buy and sell family assets" is not subjected to bargaining but decreed by "gender" to be the man's prerogative. And second, that the decision to "buy and sell family assets" is subjected to bargaining but the wife's resources such as income and education are effectively "discounted" or ignored in the bargaining process.

The above results which indicate that fertility is not a key factor in household power allocation would remove any fears that family planning may accidentally lead to the disempowerment of the Filipina in their own homes. This is because fertility, which is one of the outcomes that will likely be affected by the use of family planning, is not likely to change the balance of power in the household as indicated in the findings of this study.

G. Qualitative Inquiry on Social Construction of Work/Leisure/Rest, Power Relation, and Contraception

There are three major topics covered in the qualitative analysis, namely work, leisure and rest, decision-making in the household, and contraception.

Work, Leisure and Rest

- Work is viewed in similar perspective by urban, rural, and Muslim women. Both market and domestic activities are considered work.
- Money is an important component of being happy in their work. Preference is to work and to earn money.

- Having more children increases domestic work even for those who are engaged in market works.
- Work and leisure activities are strongly related in so far as they provide enjoyment or happiness.
- Rest is equated with leisure and associated with the notion of cessation of action in daily activities.

Decision-Making in the Household

- The man's decision prevails in Muslim households. Tradition, culture and religion give little power to Muslim women to influence household decision-making.
- Non-Muslim women affirmed joint decision undertaking in major matters. The power of women to decide increases if they are economically independent.
- Decision-making among Non-Muslim women is indeed a power play, as women reported very effective ways and means of influencing their husband's way of thinking. These include persuasion, rational/logical explanations, pretend anger, withhold love-making/sex, incessant and repetitive pleading/urging (kulit).
- Women have more liberty to decide and to act if they spend self-earned money.
- Muslim women submit to their husbands' wishes as prescribed by their religious law and to have peace in the household. It appears that Muslim women are conditioned to believe there is nothing wrong with being submissive or being dominated by their husbands.
- Division of labor is strictly followed in Muslim households. Men do productive work; women do domestic chores. Change in gender roles is believed to bring bad luck.
- Women, in general, resent doing all household works. They recognize their double burden and the fact that they are not paid.

Contraception

- Muslim women indicate that religion and tradition are the major reason why most of them do not use Family Planning.
- The burden of raising so many children forces some Muslim women to use family planning. As long as the husband approved, wives can ignore the "scorn" of the community.
- Muslim women cannot associate contraception with freer expression of sexuality or sexual desire. Religious tenets prohibit women to talk about sex or initiate sex.
- Religion is also the explanation why other Non-Muslim women refused to use family planning. Other reasons include: fear of side effects; ineffectively of the methods; and ill-health effects.
- Unanimously, Non-Muslim women viewed having fewer children and reduced risk of unwanted pregnancies as the most important benefits of family planning use. They enjoyed sex more because the fear of getting pregnant is eliminated.

- Urban women are freer in sexuality discussion with husbands especially by those who use calendar and withdrawal methods. Rural women are less open; they are ashamed to initiate the sex act or to talk about it.
- Women adopted different ways to convey refusal to have sex with husbands. The most common ways are: to plead of tiredness; to develop headaches; to pretend being asleep; and to quarrel with husbands. Few women reported never saying no for fear husband may inflict harm or may go elsewhere to satisfy sexual needs.

Recommendations

The bulk of findings from different analytical topics places the disadvantaged position of women in the center-stage of consciousness. What can be done to elevate this position so as to be at par with men? What strategies and activities can be suggested to improve the reproductive health of women? In what ways can an individual, a family, and a community synchronize their acts to enhance the quality of life for both men and women? This myriad of questions demands to be deliberated and discussed, challenging all of us, galvanizing people to act towards human resource development and to address women's concern in a holistic manner.

- The disadvantaged position of tribal and depressed communities demand priority attention and focus of development. The lack of/or inadequate provision of basic infrastructure and household amenities contribute to the disadvantaged condition of women. Electricity, better toilet facilities, and piped water can ease the domestic tasks and make women more efficient. Without these, women's burden will increase and performing domestic task becomes a never-ending, tedious, and time-consuming activity. With modern facilities and amenities, better health through improved hygiene and sanitation can also be achieved.
- Economically, women are relatively deprived but they have evolved mechanisms to cope, e.g. engaging in part-time paid work, vending farm products, and scrimping on food. These coping mechanisms have implications on gender relations and health of family members.

    - The provision of livelihood training and skill formation designed to increase the productivity of women may exacerbate the double burden. A separate analysis on women's work and family size indicated that women spend a significant portion of their daily schedule on domestic work even if they are employed.
    - To scrimp on food in order to stretch limited resources will produce serious repercussions on family health especially among growing children. Some households subsist on meager cereal with dried fish or root crops as the only component in a meal.

- It is a given that development priority should be directed to the disadvantaged places and households. Local executives, planners and program implementers are all in accord with this. However, the operationalization and program implementation remains in paper or becomes an elusive dream. In most cases, the prioritization and the actual implementation are dictated by the number of votes rather than a response to an immediate felt need.

- NGOs, religious groups and community organizations have been known to initiate and mobilize residents to act by providing support in terms of gathering accurate information and education. In some instances, NGOs have spearheaded the mobilization action or started self-help programs with initial financial support from the government. However, some efforts were not sustained much more mainstreamed into the existing community institutions.
- The study indicates the disadvantaged position of never users in term of social and economic attributes. They are deprived of reproductive health services (e.g. family planning information and education and reproductive health services). Infertility is a problem for never users and the current non-users. The clamor of women for a better family planning services has to be given priority by local government units.
- Results from empirical analyses and from FGDs confirm the findings of earlier studies that the burden of caring for younger children falls mostly on women. Urban and rural women work long hours in the home. A larger family size is likely to increase the work burden of women at home. Women experiencing the double burden and a "push--pull" of larger family size must balance involvement in income generating work and domestic tasks.
- One-fourth of women had experienced physical abuse, mostly perpetrated by husbands. Women are more likely to be the recipients of abuse by their husbands on these occasions: if women take initiative in working outside the household and deciding about the child discipline, when husbands are engaged in routine household tasks such as childcare, cleaning and marketing, or when the family is living in poverty. These results suggest strong gender role strain that could eventuate to conflict. The husbands may be doing the household chores because they are out of work or their low-paying jobs necessitate that their wives work outside the home.

Women are shown to be at a disadvantaged vis-a-vis men. Ownership of household items, which can render domestic work easy, is given low priority over entertainment items. Basically, control of resources is in the hands of men. Women cannot avail of loan without husband's approval. The decision whether a wife should work outside the home rests upon the husband. Women spend a significant portion of their daily schedule on domestic work even if they are employed. These findings underscore reproductive strategic needs. Current advocacy efforts may not produce overnight changes but definitely the wind of change is already felt. Considerable number of laws that had been passed favorable to women. To date, we have laws protecting women from sexual harassment; rape took a legal redefinition, from a crime against chastity to a crime against person and expanded to include marital rape. Mandates were given to line agencies for provision of Barangay Day Care Centers and bills are deliberated which will surely satisfy the strategic reproductive needs of women.

Coupled with efforts on changing outdated laws detrimental to women, advocacy activities of NGOs and women's groups escalated, albeit the truly disadvantaged groups of women (cultural minority, rural poor, rural adolescents) are yet to be reached for gender sensitization and empowerment. Reproductive health awareness is an area desired and needed not only by mothers but also by husbands. It is strongly suggested that efforts should be focused on adolescents whose reproductive health knowledge is minimal and revolves around body

awareness only. The school curriculum has meager offerings on sexuality and reproductive health; considerable gaps, misunderstandings and distorted views of vital aspects of reproductive health remained at high level. A Focus Group Discussion among adolescent groups revealed the quandary of the youth in their desire to know more about the topic. They were often told to shut up by parents who have minimal knowledge; they were embarrassed/ashamed to ask their teacher for fear of being ridiculed, and they cannot get full satisfaction on the responses given by peer.

On the basis of this scenario, specific recommendations are enumerated under the heading of advocacy for policy consideration, upgrading/enhancing health services with special emphasis on reproductive health, and integration of women's concerns in the development process.

Advocacy

- Study findings may be used by policy makers to promote the advantages of family planning in facilitating women's employment, particularly in the higher paying formal sector.
- Policies need to be considered that will improve women's access to technical training and higher paying formal sector work.
- Government and private employers should address the needs of working women such as on-site or community-based childcare, flexible work schedules, and should facilitate for breastfeeding including private space and refrigeration to store breastmilk.
- Women advocates can use these findings in their work on legislation and policies that would promote gender equity in the work place.
- Women's advocates can also use the results to advocate and educate concerning gender roles such as task sharing in the household, especially when women are working for pay.
- Women's organizations can use these results for increased advocacy for laws that protect women such as the "Anti-Rape" Bill.
- Educators and churches can use these results in advocating for and developing school curricula and guidelines for couples and marriage counseling.

Services

- Women's multiple work burden and time constraints support the need for women-centered health care that can provide a range of services in central locations at times convenient for women.
- Given the increased number of women in the workforce, there is needed support for programs that will provide family planning, reproductive health information, and services in the workplace.
- Sensitize FP service providers to issues of women's multiple work burdens and time constraints.
- Family planning and reproductive health clinics, especially in rural areas, may be the primary location where women can receive assistance and referrals. FP and RH providers need to be trained in providing assistance or referrals. Community volunteers and core groups staff may be tapped to carry out these services.

Consciousness Raising on Gender Equity and Women's Roles

- Since poverty and urban residence contribute to high prevalence of domestic violence, development initiatives in urban and depressed areas need to increase awareness of and resources for battered women.
- Midwives and traditional healers may also be trained to provide assistance and referrals for battered women.
- Consciousness-raising about gender and women's needs can be continued and intensified at the level of Local Government Units (LGUs) and among the barangay leaders.
- Training and information-dissemination among adolescents with special emphasis on rural and cultural minority groups.

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Appendices

A. The Interview Schedule

FAMILY HEALTH INTERNATIONAL
WOMEN'S STUDIES PROJECT

QUESTIONNAIRE

Record No. _____

I. IDENTIFICATION

Region: _____ ☐
Province: _____ ☐
Municipality: _____ ☐
Barangay: _____ ☐
Stratum:
___ Urban ☐
___ Rural ☐
Type of Area:
___ Non-depressed ☐
___ Depressed ☐
___ Tribal ☐

NAME OF RESPONDENT: _____
COMPLETE ADDRESS: _____
_____
NAME OF INTERVIEWER: _____
SUPERVISOR: _____

RECORD OF CALL

No. of Calls	Date	Interview Status	Remarks

FIELD EDITED	OFFICE EDITED	CODED BY:
NAME:	NAME:	NAME
DATE:	DATE:	DATE:

Interviewer's Comment:

_____
_____
_____
_____

Time Interview Started:

Hour _____ |___|
Minute _____ |___|

INTRODUCTION

Hello, my name is _____ and I am working with the Research Institute for Mindanao Culture, Xavier University, along with Family Health International (FHI). We are doing a research study on women's lives, family planning and reproductive health.

You have been randomly selected to participate in this study.

We would like to ask you some questions about your life and your family, the children you have had, and the work you do inside and outside of your house.

This interview will probably take a while. If you do not have time to do the interview right now, we can arrange to come back at a later time. You can refuse to answer any questions or series of questions if you choose. However, I would like to assure you that all that is said during the interview will be strictly confidential and that the information collected from you will be used only in scientific reports without any mention of your name.

Information gathered from the study will be used to improve programs that promote the well-being of women. So we hope you will give accurate answers.

If you have any questions or problems pertaining to this study, you may see Dr. Magdalena C. Cabaraban or Dr. Beethoven Morales at their offices at RIMCU, Xavier University, Cagayan de Oro City.

BLOCK I: LIFE CYCLE STAGE & OTHER PERSONAL FACTORS

1.1 Including yourself, how many persons are there in your household? _____

1.2 Please name all the persons in your household, including yourself, your husband, and your children, from the oldest to the youngest, as well as relatives and other persons who live with you. (FILL IN COL. 1.2 IN TABLE 1)

1.2.1What is the relationship of _____ to the head of the household?

1.2.2 Is _____ boy or girl?

1.2.3 In what month and year was _____ born?

1.2.4 How old is _____as of his/her last birthday? (ASK FOR PERSONS FIVE YEARS AND OVER)

1.2.5 What is the highest year/grade _____ completed?

1.2.6 Is _____ currently attending school? (0 – no or 1 – yes)

(RECORD ALL RESPONSES IN TABLE BELOW)

TABLE 1

Name 1.2	Rel. To HHH 1.2.1	Sex 1.2.2	Date Of Birth 1.2.3	Age 1.2.4	Hgc 1.2.5	Attng. School 1.2.6
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						

(IF IT IS DETERMINED THAT THE RESPONDENT IS MARRIED OR HAS A REGULAR PARTNER, ANSWER THE QUESTION FOR THE PARTNER AFTER ANSWERING THE QUESTION FOR THE RESPONDENT).

Questions	Respondent	Husband
1.3 ARE YOU: (Adapt to local situation) 1. married, spouse present 2. married, spouse absent 3. living together	|___|	
1.4 IF EVER MARRIED: How old were you when you you/your husband got married for the first time?	|___|___|	|___|___|
1.5 What is your/your husband's current occupation?		
1.6 What is your/your husband's religion? 0 - none 1 - Catholic 2 - Protestant 3 - Muslim 4 - Iglesia Ni Kristo 5 - PIC/Aglipay 6 - UCCP 7 - Others, (SPECIFY) _____	|___|	|___|
1.7 What is the primary language spoken in your household? 1. Binisaya/Cebuano 2. Tagalog 3. Ilonggo 4. Ilocano 5. Maranaw 6. Manobo 7. Other (SPECIFY) _____	|___|	|___|
1.8 How long have you/your husband lived in the present location? (ENTER NUMBER OF YEARS) 77 - all my life (SKIP TO 1.10)	|___|___|	|___|___|
1.9 Where were you/your husband born?		

1.10. What is the total monthly cash income of your household? Include in your estimates all types of cash income such as wages and salaries from employment, allowances, pensions, business income, farm income, remittances from children or relations who work here or abroad, etc.

P_____ (HH total monthly cash income) |__|__|__|__|__|__|__|__|

1.10.1 Is there a part of your household income which comes from the sale of farm products or

from the sale of animals that your family raised?

0 - No (SKIP TO 1.10.3) |___|
1 - Yes |___|

1.10.2 In your estimate, what is the cash value of the food that your household consumes out of such non-monetary sources as farm products, animals that your family raises, fishing etc.

P _____ (HH total monthly non-cash income) |__|__|__|__|__|__|__|__|

1.10.3 Does your family own a piece of land?

0 - No |___|
1 - Yes |___|

IF YES PROBE: Whose name is registered in the Title or Tax Declaration of the land?

_____

(THE FOLLOWING QUESTIONS REFER TO YOUR HOUSEHOLD AND ITS FACILITIES.)

1.11 Does you or your family own this house you are living in, do you pay rent for it, or are you staying here for free?

1 - own |___|
2 - rent |___|
3 - stay for free |___|
4 - Don't know |___|
5 - others (SPECIFY) _____

1.12 What is your usual source of drinking water?

1 - lakes, rivers, streams, etc. |___|
2 - spring |___|
3 - rainwater |___|
4 - open well |___|
5 - pump (shallow well) |___|
6 - artesian well (deep well) |___|
7 - pipe water |___|
8 - others (SPECIFY) _____

1.13 What kind of toilet facility does your household have?

1 - none |___|
2 - flush toilet |___|
3 - water-sealed toilet |___|
4 - antipolo |___|
5 - open pit |___|
6 - others (SPECIFY) _____ |___|

1.13.1 Do you have electricity in your household?

0 -No 1 - Yes |___|

|___|

1.14 Does your household have:

0 - No 1 – Yes

1. wall clock |___|
2. electric iron |___|
3. electric fan |___|
4. radio |___|
5. sala set |___|
6. sewing machine |___|
7. karaoke/cassette |___|
8. television/betamax/VHS |___|
9. refrigerator |___|
10. motorcycle |___|
11. car |___|
12. plough |___|
13. harrow |___|
14. carabao |___|
15. piece of land |___|
16. Others, (SPECIFY) _____ |___|

(OBSERVE, RATHER THAN QUESTION)

1.15 Main material of flooring (CATEGORIES SHOULD REFLECT LOW, MEDIUM, AND OR HIGH SOCIO-ECONOMIC STATUS IN THE COUNTRY. IN SOME PLACES WALLS OR CEILINGS MAYBE A BETTER MEASURE)

1 - earth |___|
2 - bamboo |___|
3 - cement |___|
4 - wood |___|
5 - linoleum/tiles |___|
6 - others, (SPECIFY) _____ |___|

1.16 Main materials of wall

1 - scrap materials |___|
2 - nipa/other thatch |___|
3 - sawali/bamboo |___|
4 - rough hewn timber/poorly fitted planks |___|
5 - painted and/well fitted boards |___|
6 - cement/hollow blocks/other expensive materials |___|
7 - others, (SPECIFY) _____ |___|

1.17 Main materials of roof

1 - scrap materials	|___|
2 - nipa/other thatch	|___|
3 - sawali/bamboo	|___|
4 - rough hewn timber/poorly fitted planks	|___|
5 - galvanized iron	|___|
6 - cement/hollow blocks/other expensive materials	|___|
7 - others, (SPECIFY) _____	|___|

BLOCK 2: CONTRACEPTIVE USE AND NON-USE

2.1 Do you know of any methods to delay or avoid pregnancy? What methods do you know of? UNPROMPTED and then PROMPTED) IF KNOWS OF THE METHOD, ASK: Do you know where you could obtain (METHOD)?

0 – No or 1 - Yes

	Spontaneous	Prompted	Where To Obtain
Modern:			
1. Pill	|___|	|___|	|___|
2. IUD	|___|	|___|	|___|
3. Injection (Depo-Provera)/Implant (Nor)	|___|	|___|	|___|
4. Diaphragm	|___|	|___|	|___|
5. Foam tablets, jelly or aerosol	|___|	|___|	|___|
6. Condom	|___|	|___|	|___|
7. Tubal ligation	|___|	|___|	
8. Vasectomy	|___|	|___|	
Periodic abstinence (rhythm):			
9. temperature (BBT)	|___|	|___|	
10. calendar	|___|	|___|	
11. symptoms	|___|	|___|	
12. Breastfeeding, LAM (lactating amenorrheic method)	|___|	|___|	
13. Withdrawal	|___|	|___|	
Herbal Contraceptives (SPECIFY):			
14 - _____	|___|	|___|	|___|
15 - _____	|___|	|___|	|___|

2.2 HAVE YOU EVER USED ANY FAMILY PLANNING METHOD?

0 - No (SKIP TO 2.5)	|___|
1 - Yes	|___|

2.3 Did you ever get pregnant while you were using a method or doing something to delay or avoid pregnancy, and if so, how many times did this happen?

0 - never (SKIP TO 2.5) |___|
1 - once |___|
2 - more than once |___|

2.4 Why do you think this happened? (CHECK AS MANY RESPONSES)

Reasons why got pregnant

1 - Method failed |___|
2 - Forgot to used method (Incl. missing pills) |___|
3 - Unable to obtain method |___|
4 - Partner didn't pull out in time
5 - Took a chance during known/suspected fertile period
6 - Pressured/forced to have unprotected sex
7 - don't know
8 - others, (SPECIFY) _____

2.5 Have you ever become pregnant at any time when you wish you hadn't?

0 - never (SKIP TO 2.9) |___|
1 - once |___|
2 - more than once |___|

2.6 What did you do about it (the last time this happened)?
(PROBE: Did you do anything to interrupt the last pregnancy you did not want?)

1 - Had the child |___|
2 - Had a miscarriage |___|
3 - Had an abortion |___|
4 - others, (SPECIFY) _____ |___|

2.7 Were there effects of the unintended pregnancy on your life? (PROBE: partner relations, family problems, other children, etc.)

0 - No (SKIP TO 2.9) |___|
1 - Yes |___|
What are these? _____
_____

2.8 How did you feel about these other effects of the unintended pregnancy on your life?
_____
_____

2.9 Have you ever become pregnant at a time when your husband/partner wished you hadn't?

0 - never |___|
1 - once |___|
2 - more than once |___|

2.10 Have you ever had difficulty conceiving? (PROBE: Tried unsuccessfully for at least a year to become pregnant?)

0 - No |___|
1 - Yes |___|

2.11 Can you (still) bear children?

0 - No |___|
1 - Yes (SKIP TO 2.13) |___|
2 - Yes, but I have no partner (SKIP TO 2.13) |___|
3 - Yes, but my partner is infertile or sterilized (SKIP TO 2.13) |___|
8 - Don't Know |___|

2.12 Why can't you (still) bear children?

1 - Post-menopausal |___|
2 - Always infertile |___|
3 - infertile now because of health problems |___|
4 - sterilized |___|
5 - others, (SPECIFY) _____ |___|
8 - don't know |___|

2.13 Breastfeeding usually delays the return of menstrual periods. Some people say that breast-feeding can prevent pregnancy. Do you believe it can, and if so, does it prevent pregnancy even after a woman's menses have returned?

0 - No |___|
1 - Yes, throughout the course of lactation (even after return of menses) |___|
2 - Yes, but only during amenorrhea |___|

2.14 Have you ever relied on breastfeeding to prevent pregnancy?

0 - No |___|
1 - Yes, throughout the course of lactation |___|
2 - Yes, but only during amenorrhea |___|

FOR EVER-USER

CHECKPOINT:
CHECK Q2.2. IF EVER USED FAMILY PLANNING CONTINUE WITH QUESTIONNAIRE. IF NEVER USED FAMILY PLANNING SKIP TO 2.26.

2.15 Are you or your partner using a method now or doing something so that you won't get pregnant?

0 - No (SKIP TO 2.26) |___|
1 - Yes |___|

2.16 What method are you using so that you won't get pregnant?

Modern:

1 - Pill	|___|
2 - IUD	|___|
3 - Injection (Depo-Provera)/Implant (Nor)	|___|
4 - Diaphragm	|___|
5 - Foam tablets, jelly or aerosol	|___|
6 - Condom	|___|
7 - Tubal ligation	|___|
8 - Vasectomy	|___|

Periodic abstinence (rhythm):

9 - Temperature (BBT)	|___|
10 - Calendar	|___|
11 - Symptoms	|___|
12 - Breast feeding, LAM	|___|
13 - Withdrawal	|___|
Herbal Contraceptives (SPECIFY):	
14 - _____	|___|
15 - _____	|___|
88 - don't know	|___|

2.17 Are you satisfied or dissatisfied with this family planning method? Would you say you are very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

1 - Very satisfied	|___|
2 - Somewhat satisfied	|___|
3 - Somewhat dissatisfied	|___|
4 - Very dissatisfied	|___|

2.18 How about your husband/partner? Is he satisfied or dissatisfied with this family planning method? Would you say he is very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied?

1 - Very satisfied	|___|
2 - Somewhat satisfied	|___|
3 - Somewhat dissatisfied	|___|
4 - Very dissatisfied	|___|

2.19 Why are you using this method? (PROBE: TO LIMIT NUMBER OF CHILDREN OR TO DELAY NEXT PREGNANCY.)

1 - limit	|___|
2 - Space	|___|
3 - others, (SPECIFY) _____	|___|

2.20 Are you having any health problems that you think may be due to using (CURRENT METHOD)?

0 - No (SKIP TO 2.22) |___|
1 - Yes |___|

2.21 What are the main health problems you believe you are experiencing using (CURRENT METHOD)? (DO NOT READ RESPONSES BUT PROBE: What else?) (CODE UP TO THREE IN ORDER OF IMPORTANCE)

1 - irregular bleeding |___|___|
2 - heavy bleeding |___|___|
3 - amenorrhea |___|___|
4 - painful periods
5 - inter-menstrual pain
6 - dizziness
7 - blurred vision
8 - chest pains
9 - hypertension
10 - varicose veins
11 - vaginal discharge
12 - headaches
13 - weight gain
14 - weight loss
15 - hair loss
16 - mood swings (irritability)
96 - others (SPECIFY) _____

2.22 Are you experiencing any Non-health related problems in using (CURRENT METHOD)? (PROBE: Such as your work, your time, for rest, your time for leisure, etc.)

0 - No (SKIP TO 2.24) |___|
1 - Yes |___|

2.23 What are the Non-health related problems you are experiencing using (CURRENT METHOD: DO NOT READ RESPONSES) (CODE UP TO THREE IN ORDER OF IMPORTANCE)

1 - inconvenience of use |___|___|
2 - inconvenience of getting more supplies of method |___|___|
3 - husband/partner doesn't like method |___|___|
4 - husband/partner doesn't like me using family planning
5 - messy to use
6 - hard to hide from children
7 - affects ability to work
8 - lack of privacy
9 - others, (SPECIFY) _____

PROBE: Why do you consider this problem/problems as not being to your health?

_____

_____

2.24 Do you plan to keep using the method?

0 - No |___|

1 - Yes |___|

2.25 Why do you plan to (Keep/Stop) using the method?

_____

_____

_____

(THEN SKIP TO 3.1)

CHECKPOINT:
TO BE ASKED FOR NON-USERS AND EVER USERS NOT CURRENTLY USING FAMILY PLANNING.

2.26 Do you intend to use a method to delay or avoid pregnancy at any time in the future?

0 - No (SKIP TO 2.31) |___|

1 - Yes |___|

2.27 What method do you intend to use? (Do you know how to use this method)

0 - No

1 - Yes

	Method	Knows how to use
Modern:		
1. Pill	|___|	|___|
2. IUD	|___|	|___|
3. Injection (Depo-Provera)/Implant (Nor)	|___|	|___|
4. Diaphragm |___|	|___|	
5. Foam tablets, jelly or aerosol	|___|	|___|
6. Condom	|___|	|___|
7. Tubal ligation	|___|	|___|
8. Vasectomy	|___|	|___|
Periodic abstinence (rhythm):		
9. Temperature (BBT)	|___|	|___|
10. Calendar	|___|	|___|
11. Symptoms	|___|	|___|
12. Breastfeeding, LAM	|___|	|___|
13. Withdrawal	|___|	|___|

Herbal Contraceptives (SPECIFY):

14. _____ |___| |___|
15. _____ |___| |___|
88 - don't know |___| |___|

2.28 Why do you use this method? (FOR EACH RESPONSE, PROBE: Why?)

1 - Limit the number of children |___|
2 - Space pregnancy |___|
3 - others, (SPECIFY) _____ |___|

2.29 What benefits do you anticipate you will receive from using the method?

_____
_____

2.30 What disadvantages do you anticipate in using the method?

_____
_____
_____

2.31 What are the main reasons why you are not using a method now or do not intend to use a method in the future? (MULTIPLE RESPONSES)

1 - Wants children |___|
2 - lack of knowledge |___|
3 - partner opposed |___|
4 - cost too much |___|
5 - side effects |___|
6 - health concerns |___|
7 - hard to get method |___|
8 - religious objection |___|
9 - opposed to family planning |___|
10 - fatalistic |___|___|
11 - other people opposed |___|___|
12- infrequent sex |___|___|
13 - difficult to get pregnant |___|___|
14 - menopausal/had hysterectomy |___|___|
15 - inconvenient |___|___|
16 - not married |___|___|
17 - husband away/migrated for employment |___|___|
18 - Others, (SPECIFY) _____ |___|___|

BLOCK 4: EXPERIENCE WITH FAMILY PLANNING PROGRAMS

4.1 What family planning services have you ever used? (ANSWERS WILL VARY BY LOCAL SETTING, BUT LARGE GROUPINGS SHOULD BE MAINTAINED). (PROBE: What else?)

0 - NO 1 - YES

Public Sector

11 - Government Hospital	|___|
12 - Government Health Center	|___|
13 - Family Planning Clinic	|___|
14 - Mobile Clinic	|___|
15 - Field Worker	|___|

Medical Private Sector

21 - Private hospital or clinic	|___|
22 - Pharmacy	|___|
23 - Private doctor	|___|
24 - Mobile clinic	|___|
25 - Field Worker	|___|

Other Private Sector

31 - shop	|___|
32 - church	|___|
33 - friends/relatives	|___|
34 - traditional medical provider	|___|
41 - Others, (SPECIFY) _____	|___|___|

4.2 Which is the family planning services you have used most recently?
(CODE NUMBER ABOVE OR 00 - NEVER USED FAMILY PLANNING SERVICES)
(SKIP TO 4.7)

_____ |___|___|

4.3 Are you currently receiving family planning from this service?

0 - No	|___|
1 - Yes	|___|

4.4 Have you experienced any problems with the family planning services you have used MOST RECENTLY? What were the problems? (CODE UP TO THREE IN ORDER OF IMPORTANCE)

0 - no problems	|___|___|
1 - dirty	|___|___|
2 - long waiting time	|___|___|

3 - far from my house
4 - rarely open/inconvenient hours
5 - staff unfriendly/not respectful
6 - staff didn't seem competent
7 - didn't offer many services

8 - shortage of supplies
9 - others, (SPECIFY) _____

4.5 Did you ever switch from one type of family planning service to another?

0 - No (SKIP TO 4.7) |___|
1 - Yes |___|

4.6 Why did you switch from the earlier family planning service? (DO NOT READ RESPONSES) (CODE UP TO THREE IN ORDER OF IMPORTANCE)

1 - dirty |___|___|
2 - long waiting hours |___|___|
3 - far from my house |___|___|
4 - rarely open/inconvenient hours
5 - staff unfriendly/not respectful
6 - staff didn't seem competent
7 - didn't offer many services
8 - shortage of supplies
9 - costly
10 - husband not supportive
11 - other, (SPECIFY) _____

4.7 Considering both facilities and personnel, what characteristics of family planning services would you consider to be the most important? (CODE UP TO THREE IN ORDER OF IMPORTANCE)

1 - clean |___|___| First order
2 - short waiting time |___|___| Second order
3 - close to my house |___|___| Third Order
4 - wide range of services/methods
5 - affordable
6 - not too busy/not crowded
7 - competent staff
8 - friendly staff
9 - privacy
10 - staff treats me with respect
11 - others, (SPECIFY) _____

4.8 What are your suggestions for making family planning services more suited to your needs? (IF NEVER USED SERVICES, ASK: Are there any chances or improvements to available services that would make it more likely that you would use them?) (PROBE IF RESPONDENT SAYS SHE DOESN'T KNOW, CODE UP TO THREEIN ORDER OF IMPORTANCE)

0 - nothing |___|___|
1 - clinic closer to my house |___|___|
2 - more doctors |___|___|
3 - more female doctors

4 - more other staff
5 - longer hours at the clinic
6 - more frequent visits by field workers
7 - more methods available, (SPECIFY) _____
8 - more services available, (SPECIFY) _____
9 - more information
10 - more time with counselor
11 - more time with the doctor
12 - less expensive
13 - provide transportation
14 - others, (SPECIFY) _____

4.9 Is it important or not important for you and for your husband/partner to have a female service provider for the following health services:

1 - important
2 - not important

1. counseling |___|
2. breast exam |___|
3. pelvic exam |___|
4. pap smear |___|
5. injection |___|
6. IUD insertion |___|
7. STD diagnosis |___|
5. Others, (SPECIFY) _____ |___|

4.10 Would you refuse to use the services if they were provided by a male provider?

0 - No
1 - Yes
2 - It depends

1. counseling |___|
2. breast exam |___|
3. pelvic exam |___|
4. pap smear |___|
5. injection |___|
6. IUD insertion |___|
7. STD diagnosis |___|
8. Others, (SPECIFY) _____ |___|

4.11 From where have you received information on family planning methods? (DO NOT READ RESPONSES)

0 - No 1 - Yes

1. health care providers |___|
2. family or friends |___|
3. community leaders |___|
4. the media (radio, TV, newspapers) |___|

5. Others, (SPECIFY) _____ |___|

4.12 With whom have you ever discussed family planning? (DO NOT READ RESPONSES)

0 - No 1 - Yes

1. current husband/partner |___|
2. mother |___|
3. other family members |___|
4. friends |___|
5. doctor or other heath care providers |___|
6. Others (SPECIFY) _____ |___|

4.13 Are you satisfied with the amount of information you have received on the contraceptive methods you have used?

0 - No |___|
1 - Yes (SKIP TO 4.15) |___|

4.14 What additional information would you like to receive to help you in your contraceptive methods you have used? (CODE UP TO THREE)

1 - menstrual cycle |___|
2 - how method works |___|
3 - side effects |___|
4 - effectiveness |___|
5 - safety |___|
6 - how to use the method |___|
7 - follow-up |___|
8 - where to get a method |___|
9 - others, (SPECIFY) _____ |___|

FOR EVER USER

CHECKPOINT:
CHECK Q2.2. IF EVER USED FAMILY PLANNING, CONTINUE WITH QUESTIONNAIRE. IF NEVER USED FAMILY PLANNING SKIP TO 4.28.

4.15 During the last time you requested a family planning method, did you ever receive the method you wanted?

0 - No (SKIP TO 4.17) |___|
1 - Yes |___|

4.16 Were you EVER refused a method that you wanted to use?

0 - No (SKIP TO 4.22) |___|
1 - Yes |___|

4.17 Which method did you want to use that was refused you?

Modern:

1 - Pill |___|
2 - IUD |___|
3 - Injection (Depo-Provera)/Implant (Nor) |___|
4 - Diaphragm |___|
5 - Foam tablets, jelly or aerosol |___|
6 - Condom |___|
7 - Tubal ligation |___|
8 - Vasectomy |___|

Periodic abstinence (rhythm):

9 - Temperature (BBT) |___|
10 - Calendar |___|
11 - Symptoms |___|
12 - Breastfeeding, LAM |___|
13 - Withdrawal |___|

Herbal Contraceptives (SPECIFY):

14 - _____ |___|
15 - _____ |___|
88 - don't know |___|

4.18 What reason was given that you could not use this method?

1 - method not available |___|
2 - temporarily out of supply of that method |___|
3 - health contraindication |___|
4 - health worker determined another method was more suitable |___|
6 - did not have husband's consent |___|
7 - others, (SPECIFY) _____ |___|
8 - don't know |___|

4.19 Were you able to obtain a different family planning method at that visit?

0 - No (SKIP TO 4.21) |___|
1 - Yes |___|

4.20 Were you satisfied or dissatisfied with the method you did receive? Would you say you were/are very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied?

1 - very satisfied |___|
2 - somewhat satisfied |___|
3 - somewhat dissatisfied |___|
4 - very dissatisfied |___|

4.21 How satisfied were you with the way you were treated at the clinic? Would you say you were very satisfied somewhat satisfied, somewhat dissatisfied or very dissatisfied?

1 - very satisfied |___|
2 - somewhat satisfied |___|
3 - somewhat dissatisfied |___|
4 - very dissatisfied |___|

4.22 Have you ever switched from using one contraceptive method to another?

0 - never (SKIP TO 4.24) |___|
1 - once |___|
2 - more than once |___|

4.23 For the most recent switch, what is the main reason you switched methods?

1 - side effects from previous method |___|
2 - forgot to take previous method |___|
3 - previous method messy |___|
4 - previous method inconvenient |___|
5 - wanted a longer term method |___|
6 - partner is now responsible for family planning |___|
7 - cost issues |___|
8 - husband/partner didn't like the method |___|
9 - method failed |___|
10 - not satisfied with provider |___|
11 - provider persuaded me to switch |___|
12 - method no longer available/supply problem |___|
13 - Others, (SPECIFY) _____ |___|

4.24 Were you ever given money or something else (such as food, clothes) when you accepted family planning?

0 - No (SKIP TO 4.28) |___|
1 - Yes |___|

4.25 Which method of contraception were you given money or other incentives to use?

Modern:

1- Pill |___|
2 - IUD |___|
3 - Injection (Depo-Provera)/Implant (Nor) |___|
4 - Diaphragm |___|
5 - Foam tablets, jelly or aerosol |___|
6 - Condom |___|
7 - Tubal ligation |___|
8 - Vasectomy |___|

Periodic abstinence (rhythm):

9 - Temperature (BBT) |___|
10 - Calendar |___|
11 - Symptoms |___|
12 - Breastfeeding, LAM |___|
13 - Withdrawal |___|

Herbal Contraceptives (SPECIFY):

14 - _____ |___|

15 - _____ |___|
88 - don't know |___|

4.26 How much money or other incentives were you given to use ***(method)***?
local currency _____ |__|__|__|__|__|__|__|
other incentives (SPECIFY) _____ |__|__|__|__|__|__|__|

4.27 Do you think the incentive influenced your decision to use the method?
0 - No |___|
1 - Yes |___|

MEN AND FAMILY PLANNING

4.28 In your opinion, have men in your (country/community) become more involved in family planning over the years in the following ways:
0 - No 1 -Yes
1. more likely to talk to wife/partner about how many children to have |___|
2. more likely to talk to wife/partner about family planning |___|
3. more supportive of wives partners' use of family planning |___|
4. more likely to use family planning themselves |___|
5. less opposition to family planning |___|
6. others, (SPECIFY) _____ |___|
7. DK

4.29 Do you think it is the responsibility of men:
0 - No 1 - Yes
1. To use contraceptive methods themselves if their wives/partners prefer |___|
2. To support their wives'/partners' use of contraception. |___|
3. To support their wives'/partners' use of contraception |___|
by paying for contraceptives or treatment of side effects. |___|
4. To encourage their wives'/partners' going to the (health centers) for check-ups. |___|
5. To support their wives'/partners' going to the health center for health problems. |___|
6. To support their wives'/partners' going to the health center by doing household chores. |___|
7. To avoid engaging in sexual intercourse outside the primary relationship. |___|
8. Others, (SPECIFY) _____ |___|

4.30 Do you think men in your community/country share these views? (REFER TO RESPONSE IN Q.29)
0 - rarely |___|
1 - sometimes |___|
2 - most of the time |___|
3 - almost always |___|
4 - not sure (SKIP TO 4.32) |___|

4.31 If you feel their views differ from yours, in what way do they differ?

_____

_____

_____

CHECKPOINT: CHECK QUESTION 4.3 IF CURRENTLY USING FAMILY PLANNING, CONTINUE WITH QUESTIONNAIRE. IF NOT CURRENTLY USING FAMILY PLANNING, SKIP TO 5.1.

4.32 Does your current family planning source provide services for men?

0 - No (SKIP TO 4.35) |___|
1 - Yes |___|
8 - Don't Know (SKIP TO 4.35) |___|

4.33 What services do they provide for men?

0 - No 1 - Yes

1. counseling |___|
2. condoms |___|
3. vasectomy |___|
4. STD screening |___|
5. treatment |___|
6. others, (SPECIFY) _____ |___|

4.34 Have you ever seen any male clients in this Health Center or family planning clinic?

0 - No |___|
1 - Yes |___|

4.35 (Are you/would you be) comfortable seeing men at the family planning clinic or other SDP?

0 - No |___|
1 - Yes |___|

4.36 In you opinion, how could the family planning program or health center better involve men?

0 - nothing |___|
1 - provide more services for men |___|
2 - provide more information for men |___|
3 - have special hours for men |___|
4 - have more male counselors |___|
5 - promote male methods |___|
6 - make men feel more comfortable in the health center |___|
7 - Have more radio/newspaper TV ads for men |___|
8 - Others (SPECIFY) _____ |___|

BLOCK 5: REPRODUCTIVE HEALTH CONCERNS AND HEALTH SERVICES

5.1 What comes to mind when you think of the term "reproductive health"? WAIT FOR SPONTANEOUS RESPONSES, THEN ASK ABOUT REMAINING ITEMS: Do you think the following are part of reproductive health?

0 - No 1 - Yes

1. ability to bear children (fertility) |___|
2. ability to choose the number of children I want to have |___|
3. ability to have a satisfying sex life |___|
4. physical, mental and social well-being |___|
5. Anything else (SPECIFY) _____ |___|

5.2 Have you ever received any of the following services at the health center?

0 - No 1 - Yes

IF RESPONSE IS NO ASK: Would you like to receive this service?

	Received	Like to Receive
a. pap smear	|___|	|___|
b. blood test	|___|	|___|
c. breast exam	|___|	|___|
d. pelvic exam	|___|	|___|
e. Reproductive Tract Infections/STD exam	|___|	|___|
f. Reproductive Tract Infections/STD treatment	|___|	|___|
g. infertility counseling	|___|	|___|
h. infertility treatment	|___|	|___|
i. prenatal care	|___|	|___|
j. postnatal care	|___|	|___|
k. nutrition counseling	|___|	|___|
l. child health care (well or sick)	|___|	|___|
m. others (SPECIFY) _____	|___|	|___|

5.3 Are there any other women's health services that I haven't mentioned that you would like to receive?

0 - No (SKIP TO 5.5) |___|
1 - Yes |___|

5.4 What other reproductive health services would you like to receive?

_____

_____

FOR EVER-USER OF FP

CHECKPOINT: CHECK Q4.1. IF EVER USED FAMILY PLANNING SERVICES, CONTINUE WITH QUESTIONNAIRE.IF NEVER USED FAMILY PLANNING SERVICES, SKIP TO 6.1.

5.5 Would you prefer to receive these services in the same location as you receive family planning services or at another location?

1 - with family planning services (SKIP TO 5.7) |___|
2 - at another location |___|

5.6 What other location would you prefer to receive these services?

_____
_____

(NOW SKIP TO 5.8)

5.7 Why would you prefer to receive these services in the same location as you receive family planning services?

_____
_____

5.8 Do you think your use or family planning services led you to use other health care services for?

0 - No 1 - Yes

1. yourself |___|
2. your children |___|
3. other family members |___|

BLOCK 6: INDIVIDUAL PSYCHOLOGICAL AND PHYSICAL FACTORS

6.1 How would you say the following aspects of your life? Are you very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied with:

1 - very satisfied 3 - somewhat dissatisfied
2 - somewhat satisfied 4 - very dissatisfied

	Respondent
a. Your life as a whole?	|___|
b. Your own health?	|___|
c. Your leisure/recreational activities?	|___|
d. Your marriage/relationship with your partner?	|___|
e. Your life apart from your marriage/relationship with your partner?	|___|
f. Your children/aspirations of your children?	|___|
g. Your job/the work you do for an income?	|___|
h. The house you live in/the way your family is living?	|___|
i. Your neighborhood/community?	|___|

j. Your relationships with friends outside of your family? |___|
h. Your involvement in religious life? |___|

6.2 Do you have any health problems that limit your normal activities, such as at your job, or taking care of your household and children?
0 - No (SKIP TO 6.5) |___|
1 - Yes |___|

6.3 What are the health problems which limit your normal activities, such as at your job, or taking care of your household and children?
_____
_____

6.4 How much of a limitation is this health problem?
1. I can do what I need to do, but have to take it easy |___|
2. I can do what I need to do, but only with severe difficulties |___|
3. I cannot do household or work tasks at all |___|
4. Others, (SPECIFY) _____ |___|

FOR EVER USER OF FP

CHECKPOINT: CHECK Q2.2. IF EVER USED FAMILY PLANNING, CONTINUE WITH QUESTIONNAIRE. IF NEVER USED FAMILY PLANNING, SKIP TO 6.10.

6.5 Please tell me about how you felt when you came home the first time with a contraceptive method? (PROBE: Did you feel relieved? Like you had more control over your life? Did you feel guilty about using family planning? Were you afraid of side effects?)
_____
_____

6.6 Has using family planning made your life worse in any way?
0 - No (SKIP TO 6.8) |___|
1 - Yes |___|

6.7 How has family planning made your life worse?
_____
_____

6.8 Has using family planning made your life better in any way?
0 - No (SKIP TO 6.10) |___|
1 - Yes |___|

6.9 How has family planning made your life better?
_____
_____

WOMAN'S ASSERTION OF SELF-ESTEEM

6.10 How would you feel if your husband humiliates you in public?

_____

_____

What will you do? _____

_____

6.11 How would you feel if your husband will inflict physical harm on you?

_____

_____

What will you do? _____

_____

6.12 How would you feel if your husband will not entrust his earnings to you?

_____

_____

What will you do? _____

_____

6.13 How would you feel if you will learn that your husband is having an affair with another woman?

_____

_____

What will you do? _____

_____

6.14 How would you feel if your husband will not consult you whenever he makes an important decision?

_____

_____

What will you do? _____

_____

6.15 Does your husband permit you to socialize with your neighbors or friends?

0 - No |___|

1 - Yes |___|

Why? _____

_____

6.16 Does your husband permit you to read any magazine or absorb any information that you want?

0 - No |___|

1 - Yes |___|
Why? _____
_____

6.17 Does your husband permit you to rest or engage in any leisurely activity?
0 - No |___|
1 - Yes |___|
Why? _____
_____

DOMESTIC VIOLENCE

6.18 Are there instances when you or your husband inflict bodily harm to each other?
0 - No |___|
1- Yes |___|

6.19 How often does this happen?
1 - too often |___|
2 - often |___|
3 - seldom |___|
4 - never |___|

6.20 What are these instances?
_____
_____

6.21 What are specific bodily harms inflicted to you or you inflicting to your husband?
_____
_____

6.22 Are the following acts inflicted to you or either you inflicting these to your husband and how often?
0 - No 1 - Yes
1 - throwing things |___|
2 - punching |___|
3 - slapping |___|
4 - kicking |___|
5 - choking |___|
6 - finding faults |___|
7 - name calling |___|
8 - humiliating you in front of others |___|
9 - yelling |___|
10 - smashing things |___|
11 - putting down important people in your life |___|
12 - false accusation |___|

13 - untruthfulness |___|
14 - insulting you in front of others |___|

BLOCK 7: FAMILY AND HOUSEHOLD CHORES. PARTNER AND HOUSEHOLD COMMUNICATIONS.

7.1 Given your present circumstances (e.g. income, employment, partner relations, etc.), are you happy with the number of children you have now, would you like to have more, or do you wish you didn't have so many?

1 - right number (SKIP TO 7.3) |___|
2 - wants more |___|
3 - wants fewer |___|

7.2 Why do you have (MORE/FEWER) children?

_____
_____

7.3 How about your husband/partner, is he happy with the number of children you have now, would he like to have more, or does he wish you didn't have so many?

1 - right number (SKIP TO 7.3) |___|
2 - wants more |___|
3 - wants fewer |___|

7.4 Why do you think your husband wishes you had (MORE/FEWER) children?

_____
_____

CHECKPOINT: (Q.7.5 IS TO BE ASKED ONLY WHEN RESPONSE IN Q7.1 AND 7.3 DIFFER OTHERWISE SKIP TO 7.8)

7.5 Has wanting different numbers of children been a source of tension between you and your husband/partner?

0 - No (SKIP TO 7.8) |___|
1 - Yes |___|

7.6 Can you describe the nature of the tension between you and your husband/partner?

_____
_____

7.7 How has the tension between you and your husband/partner been resolved?

_____
_____

7.7 Has wanting different numbers of children been a source of tension between you and your husband's/partner's family?

0 - No
1 - Yes

FOR EVER USER OF FP

CHECK Q2.2. IF EVER USED FAMILY PLANNING, CONTINUE WITH QUESTIONNAIRE.
IF NEVER USED FAMILY PLANNING, SKIP TO 7.27.

7.8 Now that you are using family planning or when you were using family planning before, do (did) you find it easier or more difficult to talk to your husband/partner about household matters, or is there no difference?

1 - easier |___|
2 - more difficult |___|
3 - no difference |___|

7.9 Do you feel that using family planning has helped you have the number of children you want?

0 - No |___|
1 - Yes (SKIP TO 7.11) |___|
2 - in part |___|

7.10 (IF NO OR ONLY PARTLY) Why not?

_____
_____

7.11 Does your husband/partner NOT know that you use family planning?

0 - No |___|
1 - Yes (SKIP TO 7.13) |___|

7.12 Why does your husband/partner NOT know that you use family planning?

_____
_____

7.13 Have you ever asked your husband/partner how he feels about family planning?

0 - No |___|
1 - Yes |___|

7.13.1 Has your husband/partner told you how he feels about family planning?

0 - No |___|
1 - Yes |___|

7.14 How does your husband/partner feel about family planning or what do you think his opinions are? (CODE UP TO THREE IN ORDER OF IMPORTANCE.)

1 - supports family planning |___|___|
2 - does not support family planning |___|___|
3 - thinks it is good for the country |___|___|
4 - thinks it is good for the health
5 - worries about my health
6 - agrees for me to use but not for him
7 - does not agree for me to use it
8 - agrees that it is good to have few children
9 - uses it himself or would consider using it
77 - others, (SPECIFY) _____
88 - DK

7.15 If he is not using a method himself, does your husband/partner help or hinder your use of FP, or does he experience any effect?

0 - using method himself |___|
1 - helps |___|
2 - hinders |___|
3 - has no effect |___|

7.16 Have you ever asked your husband/partner to use a family planning method?

0 - No |___|
1 - Yes |___|

7.17 Has your husband/partner ever used family planning? What method has he used most recently?

00 - never used a method(SKIP TO 7.19) |___|___|
01 - Condom
02 - Vasectomy
03 - Periodic abstinence (rhythm)
04 - Withdrawal
88 - Don't Know

7.18 Is your husband/partner using family planning now?

0 - No |___|
1 - Yes (SKIP TO 7.20) |___|

7.19 Would you like your husband/partner to use family planning?

0 - No |___|
1 - Yes |___|

7.20 When you first decided to use family planning, did you tell other household members?

0 - No |___|
1 - Yes |___|

7.21 Have you ever stopped using a family planning method because your husband/partner or another person wanted you to stop?

0 - No (SKIP TO 7.24) |___|
1 - Yes |___|

7.22 Who made you stop using a method?

1 - husband/partner |___|
2 - mother |___|
3 - mother-in-law |___|
4 - father |___|
5 - father-in-law |___|
6 - children |___|
7 - priest |___|
8 - grandmother |___|
9 - grandmother-in-law |___|
10 - grandfather |___|
11 - grandfather-in-law |___|
12 - brother |___|
13 - brother-in-law |___|
14 - sister |___|
15 - sister-in-law |___|
16 - others (SPECIFY) _____ |___|

7.23 Why did that person make you stop using the method of family planning?

1 - wanted me to have more children |___|
2 - worried about my health |___|
3 - religious opposition to family planning |___|
4 - others (SPECIFY) _____ |___|

PARENTING

7.24 Do you think that your use of family planning has allowed you to spend more time or less time, or has it made no difference to the time you spend with your children?

1 - more time |___|
2 - less time |___|
3 - no difference |___|

7.25 Do you think your use of family planning has affected your aspirations for your children (what your children will do or be when they are grown up)?

0 - No (SKIP TO 7.27) |___|
1 - Yes |___|

7.26 How do you think your use of family planning has affected or will affect your children's future?

_____

_____

7.27 Would you advice a daughter to use family planning?

0 - No |___|
1 - Yes (SKIP TO 7.29) |___|

7.28 Why would you (not) advice a daughter to use family planning?

_____

_____

7.29 Would you advice a son to use family planning?

0 - No |___|
1 - Yes (SKIP TO 7.31) |___|

7.30 Why would you (not) advice a son to use family planning?

_____

_____

SEXUALITY AND SEXUAL BEHAVIOR

7.31 If there have been times when you and your current husband/partner didn't use family planning did you have sexual relations more often, less often or about the same?

1 - more often |___|
2 - less often |___|
3 - about the same amount |___|

7.32 Do you feel that using your current method of family planning affects your sexual relations in any other ways? How? (DO NOT READ RESPONSES) (CODE UP TO THREE IN ORDER OF IMPORTANCE)

0 - no effect |___|
1 - makes it more spontaneous |___|
2 - makes it less spontaneous |___|
3 - I don't worry about pregnancy
4 - I worry about contraceptive failure
5 - My husband worries I am having sex outside of marriage
6 - I enjoy sex more
7 - I enjoy sex less
8 - I am less interested in having sex
9 - I am more interested in having sex
10 - others, (SPECIFY) _____

(FOR EVER-USER SKIP TO Q7.35) FOR NEVER-USERS OF FAMILY PLANNING

7.33 Do the following people approve or disapprove of family planning?
Code: 1-approve, 2-disapprove, 3-no opinion, 8-don't know

	Approval
1. husband/partner	|___|
2. mother	|___|
3. mother-in-law	|___|
4. father	|___|
5. father-in-law	|___|
6. children	|___|
7. priest	|___|

7.34 How do you think your partner/other close relatives would react if you began using family planning?

_____

TASK ALLOCATION

7.35 Who is responsible for the following tasks in your household? Are you responsible? Or your husband? Or the two of you? Or is it other persons who are responsible for these tasks? (READ TASKS IN TABLE BELOW AND PUT CHECK IN THE APPROPRIATE COLUMN.)

Tasks	Wife	Husband	Both	Others
a. Earn a living				
b. Cooking				
c. Cleaning/washing after cooking				
d. Marketing tasks				
e. Control of household budget				
f. Cleaning the house				
g. Washing and ironing of clothes				
h. Taking care of the children				
i. Caring for sick children				
j. Caring for the elderly				
k. Accompanying children to school				
i. Repairs in the house				
m. Raising/feeding backyard animals				
n. Gardening				
o. Attending barangay activities/affairs				

TIME ALLOCATION

7.35.1 During the day, how much time (hours) do you allocate for household work?
_____ (No. of hours) |___|___|

7.35.2 What are the types of work/activities you do first thing in the morning and until bedtime? Do you do these everyday, every week, every other day, etc.? How many hours did you allocate for these?

Activities	When to do	# of Hours
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

7.35.3 Do you have a maid or household help?

0 - No (SKIP TO Q.11.5) |___|
1- Yes |___|

7.35.4 Is the household help related to you?

0 - No |___|
1- Yes |___|

7.35.5 Why do you think a maid/household help is necessary for you?

_____
_____

(SKIP TO 7.35.7)

7.35.6 Who usually assists you in your household chores?

1 - husband |___|
2 - children |___|
3 - nephew/niece/aunt/mother |___|
4 - distant relatives |___|

7.35.7 What are the usual tasks that a maid/house-help/assistant does?

_____
_____

7.35.8 Do you pay incentives to any of these people in assisting you?

0 - No |___|

1- Yes |___|

7.35.9 What and how much incentive do you give?

_____
_____

7.35.10 In what ways do you think they help you?

_____
_____

7. 36 Who decides on the following? Is it you? Your husband? Or the two of you? Or other persons? (IF RESPONSE IS BOTH ASK: If you and your husband's decision do not coincide or your decisions are in conflict, whose decision will prevail?)

Who Decides	Wife	Husband	Both	Others	Whose Decision Will Prevail
a. What to buy in the market or what to cook for the family					
b. When buying expensive things for the household such as radio, TV, etc.					
c. How many children to have					
d. What family planning method to use					
e. Giving of assistance and support to parents, in-laws, siblings etc.					
f. Who to vote during elections					
g. Visits to relatives and friends					
h. Buying items for personal grooming					
i. Selling or buying of items for family such as jewelry, car, house, land etc.					
j. Working outside the household					
k. Hire or obtain the services of a servant					
l. During quarrels or conflicts, who initiates reconciliation first					
ASK IF R HAS CHILDREN					
m. Disciplining the children					
n. What to do when children are sick					
o. What course the children will take or until what level of schooling will they be supported by the family					
p. The school where the children will study					
q. Decisions pertaining to the choosing of spouses for the children					
r. Friends that children are allowed to go with					
ASK IF PARENTS DIFFER IN RELIGION					
s. Whose religion will the children follow					

BLOCK 8: COMMUNITY AND SOCIETY ROLES

EMPLOYMENT STATUS. CHECK Q1.5. IF CURRENTLY EMPLOYED FOR PAY, CONTINUE WITH QUESTIONNAIRE. IF NOT EMPLOYED, SKIP TO 8.11

8.1 Is your current paid work at home or outside the home?

1 - at home	|___|
2 - outside the home	|___|

8.2 Is this work in a family owned business?

0 - No	|___|
1 - Yes	|___|

8.3 Are you self-employed?

0 - No	|___|
1 - Yes	|___|

8.4 Please describe the type of work do you do.

_____

_____

8.5 How satisfied are you with your employment situation?

1 - very satisfied	|___|
2 - somewhat satisfied	|___|
3 - somewhat dissatisfied	|___|
4 - very dissatisfied	|___|

8.6 How are you paid?

1 - wage, non-contractual payment	|___|
2 - wage, on a contractual basis	|___|
3 - on probation period	|___|
4 - by the piece	|___|
5 - on commission	|___|
6 - in kind	|___|
7 - for own profit (self-employed)	|___|
8 - unpaid worker	|___|
9 - wage, irregular	|___|
10 - others (SPECIFY) _____	|___|
88 - DK/NR	|___|
99 - NA	|___|

8.7 What is your monthly gross income?

_____ (Monthly Gross Income) |__|__|__|__|__|__|__|__|

8.8 What do you normally do with the money you earn?

_____

_____

8.9 Do you supervise other workers? IF YES, how many? (Number of people wholly or particularly supervised)

_____ Enter "00" if no supervisers.

8.10 Do you have any of the following benefits through your employment?

0 - No 1 - Yes

1 - sick leave	|___|
2 - vacation	|___|
3 - maternity leave	|___|
4 - retirement/pension	|___|
5 - health insurance	|___|
6 - life insurance	|___|
7 - disability insurance	|___|
8 - child care	|___|
9 - educational benefit	|___|
10 - bonuses	|___|
11 - allowances	|___|
12 - housing	|___|
13 - food	|___|
14 - hazard pay	|___|
15 - loan benefits	|___|

16 - others (SPECIFY) _____

8.11 What is your husband's average monthly gross income?

_____ (Monthly Gross Income) |__|__|__|__|__|__|__|__|

8.12 Do you know of any loan sources in your community?

0 - No (SKIP TO 8.19)	|___|
1 - Yes	|___|

8.13 What are these loan sources?

_____

_____

8.14 Have you ever participated in any loan programs?

0 - No (SKIP TO 8.19)	|___|
1 - Yes	|___|

8.15 What type of loan is this?

_____
_____

8.16 For what did you use the loan amount?

_____
_____

8.17 Is this loan source for women only?

0 - No |___|
1 - Yes |___|

8.18 Is the husband's approval a requirement for the loan?

0 - No |___|
1 - Yes |___|

MATERNAL MORBIDITY AND MORTALITY

8.19 In the past three years, have you heard of somebody here in your community who died during her pregnancy or during the giving of birth or within a month after giving birth?

0 - No (SKIP TO 8.23) |___|
1 - Yes |___|

8.20 IF YES: How many women?

_____

8.21 Who are they?

_____
_____

8.22 What were the cause/causes of their deaths?

_____
_____

8.23 What is the usual illness of pregnant women or women who had just given birth here in your community?

_____
_____

PARTICIPATION IN COMMUNITY ACTIVITIES

8.24 Do you think it is good for women to participate in community activities?

0 - No |___|
1 - Yes |___|

8.25 Why do you think it is (not) good for a woman to participate in such community activities?

_____

_____

8.26 Do you participate in any community activities?

0 - No (SKIP TO 8.28) |___|
1 - Yes |___|

8.27 What kind of activities do you participate in? (CODE UP TO THREE)

1 - mother's club |___|___|
2 - women's group |___|___|
3 - church activities |___|___|
4 - community development
5 - HIV/AIDS prevention
6 - other health-related activity
7 - local cooperative programs
8 - others, (SPECIFY) _____

COMMUNITY STATUS

Please think of a woman in your community whom you think has high status. (Whom other women admire who is important in the community.)

8.28 What are the traits of a woman you find admirable? (How is this woman different from other women)

_____

_____

8.29 What are the traits of a woman you find pitiful?

_____

_____

8.30 How do people in your community perceive women who use family planning? Do they perceive them to have high status or low status, or does family planning have no effect on status?

1 - high status |___|
2 - low status |___|
3 - it depends |___|
4 - no effect on status (SKIP TO 8.32) |___|

8.31 Why do you think women who use family planning have (high/low) status in your community?

_____

_____

SECURITY IN OLD AGE

8.32 What do you think a person needs to feel secure in their old age? (CODE UP TO THREE)

1 - sufficient money |___|___|
2 - a husband/partner |___|___|
3 - at least one child |___|___|
4 - many children
5 - at least one son
6 - many sons
7 - at least one daughter
8 - many daughters
9 - a place to live
10 - good health
11 – others (SPECIFY) _____

8.33 When you are old, what do you expect to be your major source or sources of financial support? (CODE UP TO THREE)

1 - son(s) |___|___|
2 - daughter(s) |___|___|
3 - other relatives |___|___|
4 - savings
5 - land
6 - rent/dividend/interest
7 - pension
8 - own earnings
9 - government aid
10 - others (SPECIFY) _____

8.34 Do you think women who use family planning and have limited their number of children will have more security or less security in old age?

1 - more security |___|
2 - less security |___|
3 - number of children less important than other factor |___|
8 - don't know |___|

8.35 Why do you think women who use family planning will have (MORE/LESS) security in old age?

_____
_____

EFFECT OF FAMILY PLANNING ON LIFE

CHECK Q.2.2. IF EVER USED FAMILY PLANNING, CONTINUE WITH QUESTIONNAIRE. IF NEVER USED FAMILY PLANNING, SKIP TO 8.41.

8.36 Do you think that using family planning has/will allow you to: (ASK EACH QUESTION)

0 - No 1 - Yes

1 - obtain more education |___|
2 - obtain more job training |___|
3 - spend more time at your work |___|
4 - be more efficient in your work |___|
5 - advance in your position at work |___|
6 - earn more income |___|
7 - be more satisfied in your work |___|
8 - have more leisure time |___|
9 - participate in a loan program for women |___|
10 - participate in community activities |___|
11 - spend more time in community activities |___|
12 - Take a leadership role in community activities |___|
13 - be more satisfied with these community activities |___|

8.37 Do you think your life would be different now if you had NOT used family planning?

0 - No (SKIP TO 8.39) |___|
1 - Yes |___|

8.38 Please tell me how you think your life would be different if you had NOT used family planning?

_____
_____

8.39 Do you have anything else to add on the effect, either positive or negative, that family planning has had on your life?

_____
_____

8.40 What are these?

_____
_____

(**SKIP TO 9.1)**

QUESTIONS FOR NON-USERS OF FAMILY PLANNING

8.41 Do you think your life would be different now if you had used family planning?

0 - No (SKIP TO 8.43) |___|
1 - Yes |___|

8.42 Please tell me how you think your life would be different if you had used family planning?

_____
_____

8.43 Do you have anything else to add on the effect, either positive or negative, that your childbearing experience has had on your life?

0 - No (SKIP TO 9.1) |___|
1 - Yes |___|

8.44 What are these?

_____
_____

BLOCK 9: PERCEPTION OF WOMEN ON EFFECT OF FAMILY PLANNING TO LEISURE/RESTAND IDEA OF QUALITY CARE

9.1 Does use of family planning have an effect on women's ability to rest or engage in leisurely activities?

0 - No (SKIP TO 9.2) |___|
1 - Yes |___|

9.1.1 What are the effects of family planning use on women's ability to rest or engage in leisurely activities?

_____
_____

9.2 Is there an effect on a woman's ability to rest or engage in leisurely activities if she is not using family planning?

0 - No (SKIP TO 9.3) |___|
1 - Yes |___|

9.2.1 What are the effects on a woman's ability to rest or engage in leisurely activities if she is not using family planning?

_____
_____

9.3 Does use of family planning have an effect on the quality of a woman's children?

0 - No (SKIP TO 9.4) |___|
1 - Yes |___|

9.3.1 What are the effects of family planning use on the quality of a woman's children?

_____
_____

9.4 Is there an effect on the quality of a woman's children if she does not use family planning?

0 - No (SKIP TO 9.5) |___|
1 - Yes |___|

9.4.1 What are the effects on the quality of a woman's children if she does not use family planning?

_____
_____

9.5 What do you think are the characteristics of a child with quality?

_____
_____

9.6 At the moment, can you say that you have a child who has quality?

0 - no |___|
1 - yes |___|

9.7 Why?

_____
_____

9.8 Does the care of children take up a huge portion of your time?

0 - no |___|
1 - yes |___|

9.9 Why?

_____
_____

9.10 What age can a child be depended on to take care of his/her younger siblings? _____(Age)

9.11 Why?

_____
_____

BLOCK 10: PREVENTIVE HEALTH CARE

10.1 Do you take measures to protect your health?

0 - No |___|
1 - Yes |___|

Respondent IF YES: What are these measures? (DO NOT READ RESPONSES)

1. Wash reproductive organs regularly, especially during mornings and evenings. |___|
2. Take a bath every day |___|
3. Change clothes every day |___|
4. Change panties every day |___|
5. Brush teeth regularly |___|
6.
7.
8.
9. Other, (SPECIFY) _____

10.1.1 Does your husband take measures to protect his health?

0 - No |___|
1 - Yes |___|
What are these? _____
_____

10.2 Have you noticed if you have vaginal secretions?

0 - No (SKIP TO 10.6) |___|
1 – Yes |___|

10.3 Would you please describe the usual forms of these vaginal secretions?

_____
_____

10.4 Are there times when the secretions are different?

0 - No (SKIP TO 10.6) |___|
1 - Yes |___|

10.5 Please describe these secretions.

_____
_____

10.6 Have you experienced pain and itching in your vagina?

0 - No (SKIP TO 10.8) |___|
1 - Yes |___|

10.7 What did you do about it?

_____
_____

10.8 Have you experienced pain while urinating?

0 - No (SKIP TO 10.10) |___|
1 - Yes |___|

10.9 What did you do about it?

_____
_____

10.10 Have there been times when you noticed blood or bleed after having sex with your husband?

0 - No |___|
1 - Yes |___|

10.11 Are you informed about sexually transmitted diseases?

0 - No (SKIP TO 10.13) |___|
1 - Yes |___|

10.12 What sexually transmitted diseases are you knowledgeable about?

_____
_____

10.13 Have you heard about AIDS?

0 - No |___|
1- Yes |___|

10.14 What have you heard about AIDS?

_____
_____

10.15 What are the ways in which AIDS can be transmitted from one person to another?

_____
_____

Thank you for participating in this study and for taking the time to answer these questions.

10.16 Record the time when the interview ended

Hour _____ |___|
Minute _____ |___|

B. The FGD Pre-survey Guide Questions

1) Concept of Work, Leisure, and Rest

- What is your definition of work? In your daily activities, when do you consider a chore as work?
- What time in a day do you think you are free from household chores?
- What are the conditions or circumstances in which you can say you are free from work?
- If you are free from domestic work, what are the things that you would like to do?
- Do you find satisfaction in the things that you like doing, if you are free from your domestic duties?
- From the time you wake up in the morning up to the time you go to bed, how many hours do you think you are free from your work?
- What is your understanding of the word rest?
- What are the things you do when you are relaxing?
- What is rest to you?

2) Decision-making

- On decision-making in the household, whose decision is always followed in your home?
- When you think your husband's decision is wrong and you think you are right, whose decision prevails?
- Do you have ways or means how to circumvent his decision so that your own will be followed?
- What are the decisions in which you think there is no need to consult your husband? When do you think you can decide alone?
- When you are marketing for your household consumption, is there a need to consult your husband on what food to buy?
- On decisions regarding the manner of bringing up your children, like when your child is sick, do you think you need your husband decision, or can you decide yourself?
- When you want to bring your sick child to a doctor and your husband refuse, what will you do?
- In buying things for personal grooming, do you seek your husband permission first before buying it? Or do you go and buy it without asking your husband?
- Do you have your own income?

3) Relationship with Spouse

- In your relationship with your husband as a Muslim wife, do you think you have to always follow your husband? Or do you think yourself as an equal to your husband? Where do you think you stand in your relationship with your husband?

- Are there times when you can say we are equal?
- The situation of always following your husband, is this what you really want? Do you think it is unfair to you? Are you satisfied in this?
- Do you think there are cases when a husband hits his wife? What do you think of it? What can you say about it?
- In your community, is there a case of a husband hitting his wife?

4) Contraception

- Does contraception makes you feel guilty or in control of your life?
- Does the use of family planning enhance sexuality discussion between you and your husband?
- In what ways could you convey refusal to have sex especially in instances when you do not fell like having sex?

C. The FGD Post-survey Guide Questions

1. Unwanted Pregnancies

- When is a pregnancy unwanted? (high rate of unwanted pregnancies)
- Why are there unwanted pregnancies?
- What are the reasons?
- Why is it not prevented?
- What happens after knowing that you are pregnant?
- What do you feel later?
- Why an unwanted pregnancy adds burden (economic) and stress to husband-wife relations?

2. Task Allocation

- Who among the family members determine what task or role to do in the household?
- Why do you think household chores are only for the wife?
- Do you think a husband can do reproductive task like taking care of the children, and other household chores like washing of clothes and cooking meals?
- Are you happy and satisfied with all the household tasks?
- (Note: Do women do tasks as a sense of obligation with regard to consequences?)
- How do you view responsibility (e.g. child discipline)?
- Who influence the decision regarding tasks? What do you feel when doing a task that you think should be done by a man?
- For all your efforts in coping with household chores and earning, does your husband realize the contributions you are making?

3. Decision-making

- In what instance shall the male make the decision?
- In what instances shall you make the decision for your children?
- In what household concerns shall you initiate decision-making?
- What decision-making problem do you decide jointly? In case of conflict, whose decision prevails? Will you agree? How will you convince your husband to change his decision in favor of yours?
- Who decides to make up after a quarrel?
- Who influences you on what religion to take, whom to vote during election, when to visit friends and relatives?

4. Domestic Violence

- What are the usual instances where the husband physically abuses his wife? What are these types of physical abuse?
- Why is the wife battered? What are the reasons why this happens?
- Who usually starts the physical battering?
- What will the wife usually do after experiencing physical abuse?
- What are the effects of these acts of physical violence to the children?

5. Income

- When income needs to be augmented or there is a shortfall, what is the usual coping mechanism (e.g getting credit)? Who takes care of this?
- Does having more children increase your desire to earn more?
- Where do you get the money to spend for the children?

D. The Oral Consent Form

From # _____
Barangay _____
Municipality_____
Province_____
Household #_____

Research Institute for Mindanao Culture (RIMCU)
Family Health International - Women's Studies Project

Oral Informed Consent for Interviewers

(INTERVIEWER READ THE OBJECTIVES OF THE STUDY)

This study is on the social and economic consequence of family planning. Specifically we are investigating whether the use or non-use of family planning brings about an improvement in women's social-psychological well-being, her family roles and personal relations, her employment chances and opportunities, her reproductive health, her use of leisure and rest, and her participation in the community.

The interview includes sensitive and intimate questions. It will take on the average, one and half hours to answer these questions. You may choose whether or not your name may be recorded.

Your participation in this interview is voluntary. You may refuse to answer any questions in the interview or stop the interview at any time.

In case you want to know more about this study, or in the event that any harm will arise from asking our questions, we refer you to the following:

1. Dr. Magdalena C. Cabaraban
   Principal Investigator
   Research Institute for Mindanao Culture
   Cagayan de Oro City

2. Dr. Beethoven Morales
   Co-Investigator
   Research Institute for Mindanao Culture
   Cagayan de Oro City

3. Dr. Linda M. Burton
   Director
   Research Institute for Mindanao Culture
   Cagayan de Oro City

4. Dr. Nerius O. Acosta
   Ethics Review Board Member
   & Provincial Board Member
   Province of Bukidnon

_____ _____

Signature of person obtaining consent **Date**

E. The Referral Card

REFERRAL CARD

TO: _____

FROM:
Women's Studies Project
Research Institute for Mindanao Culture
Xavier University
Cagayan de Oro City

In consonance with our study objectives and in the desire to help women, we are referring_____ _____ to you. We appreciate any assistance you may extend in the areas of counseling, referral, information/education, and possible training that she may need.

SERVICES SOUGTH

Counseling	☐
Referral	☐
Information/Education	☐
Livelihood Training	☐

(Cooperative formation, etc.)